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FOR STATE
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										05377																
5407										Reg. Dist. No.																
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore																					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River #20			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Middle River #20			d. STREET ADDRESS 20 Seneca Gardens Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 20 Seneca Gardens Road					4. DATE OF DEATH Last Month Day Year May 22, 1960																					
3. NAME OF DECEASED (Type or print)		First Middle		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 6, 1884		9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired					10b. KIND OF BUSINESS OR INDUSTRY Tugboat					11. BIRTHPLACE (State or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME John H. Adams					14. MOTHER'S MAIDEN NAME Chessie Fitchett					15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWI					16. SOCIAL SECURITY NO. 217-14-5238					17. INFORMANT Anna J. Adams Same					Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					Coronary Occlusion					INTERVAL BETWEEN ONSET AND DEATH 1 mo																
Arterio Sclerotic Heart Dis.															6 years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). Duodenal Ulcer - 13 P.T.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
19																										
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										ACTUAL SIGNATURE Jack C. Collins																
EXAMINER'S NAME (Type)					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED 5-22-60																
22a. BURIAL/CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 5/26/60			22c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn Cemetery			22d. LOCATION (City, town, or county) Baltimore Co., Maryland		(State)		24a. REC'D BY REGISTRAR MAY 24 '60		24b. REGISTRAR'S SIGNATURE John S. Kline												
23. FUNERAL DIRECTOR'S SIGNATURE James E. Bruzdowski 1407 Eastern Ave.					ADDRESS																					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film G263 5-20-60 et

5408

CERTIFICATE OF DEATH

05378

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Villa Nova		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Villa Nova	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7108 Queen Anne Road		d. STREET ADDRESS 7108 Queen Anne Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First HARRY	Middle R.	Last ADAMS
4. DATE OF DEATH	Month May	Day 4	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1887 9. AGE (In years last birthday) 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer	10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Detroit	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Adams	14. MOTHER'S MAIDEN NAME Unknown	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 214-18-0623	INFORMANT Maude M. Adams - 7108 Queen Anne Rd.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
b. <i>carcinoma of stomach - with metastasis to liver - etc. -</i> INTERVAL BETWEEN ONSET AND DEATH 1 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arterio sclerosis.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 6 - 1953 to May 4 - 1960 that I last saw the deceased alive on April 28 - 1960 , and that death occurred at 8:47 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl L. Chambers		ADDRESS (Street, city or town, state) 4108 Liberty Hts - Balt - Md. 21217	
PHYSICIAN'S NAME (Type) EARL L. CHAMBERS		DATE SIGNED 5-4-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/6/1960	
22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge Cemetery		22d. LOCATION (City, town, or county) Pikesville (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		ADDRESS 4600 Liberty Hts. Ave.	
24a. REC'D. BY REGISTRAR MAY 9 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Chase	
DATE			

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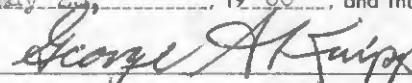
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5409

CERTIFICATE OF DEATH

05379
Reg. Dist. No. 1

1. PLACE OF DEATH a. COUNTY Balto.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 22 Nunnery Lane		d. STREET ADDRESS 22 Nunnery Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First HIRAM	Middle 	Last AIREY
4. DATE OF DEATH	Month May	Day 25	Year 1960
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1880
9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months 	11. IF UNDER 24 HRS Days 	12. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales. Ret.		10b. KIND OF BUSINESS OR INDUSTRY Insurance	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Airey		14. MOTHER'S MAIDEN NAME Catherine Carle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Allyne A. Airey 22 Nunnery Lane		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis INTERVAL BETWEEN ONSET AND DEATH 177X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Adeno-carcinoma of prostate (c) DUE TO DUE TO DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardio vascular disease INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 8, 1960, to May 25, 1960, that I last saw the deceased alive on May 25, 1960, and that death occurred at 9:15 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) George A. Knipp, M. D. 4116 Edmondson Avenue DATE SIGNED 5/27/60			
ACTUAL SIGNATURE 		PHYSICIAN'S NAME (Type) George A. Knipp, M. D. Baltimore 29, Maryland	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 5-28-60	
22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cem.		22d. LOCATION (City, town, or county) Balto.	
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home		ADDRESS Ctaonsville, Md.	
24a. REC'D BY REGISTRAR DATE MAY 31 '60		24b. REGISTRAR'S SIGNATURE Charles S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
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2012



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G263 5-23-60 et

5410

CERTIFICATE OF DEATH

Reg. No. 05380

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Owings Mills</i>		c. LENGTH OF STAY IN 1b <i>—</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>*Owings Mills</i>	
3. NAME OF DECEASED (Type or print) <i>Harry E. Albright</i>		First <i>Harry</i>	Middle <i>E.</i>
4. DATE OF DEATH Month <i>May</i>	Day <i>15</i>	Year <i>1960</i>	5. SEX <i>M</i>
6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 18, 1892</i>	9. AGE (In years last birthday) yrs. <i>62</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>farm</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>William Albright</i>		14. MOTHER'S MAIDEN NAME <i>Alberta Whittington</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-12-2374</i>	17. INFORMANT <i>Mrs. Gladys Miller</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i>		Address <i>Hampstead, Md.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Anteriorischemic C.V.D.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>4 March</i> , 19 <i>48</i> , to <i>May</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>2 May</i> , 19 <i>60</i> , and that death occurred at <i>447 E P M</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles H. Williams</i>		ADDRESS (Street, city or town, state) <i>1632 Reisterstown Road</i>	
PHYSICIAN'S NAME (Type) <i>Charles H. Williams</i>		DATE SIGNED <i>8 May 1960</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>May 19, 1960</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Bosley Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Cockeysville, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. F. Eline & Sons</i>		ADDRESS <i>Reisterstown, Md.</i>	24e. REC'D BY REGISTRAR DATE <i>MAY 17 '60</i>
			24b. REGISTRAR'S SIGNATURE <i>C. Eline & Sons</i>

01-39047-11000-000000 STATE CHARTER

11000 TO STANFORD 0100

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FOR STATE
HEALTH DEPT.

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TO DIVISION MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3, page 5 must be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

541 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06553

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residencia before admission)		b. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Owings Mills, Md.		d. STREET ADDRESS 120 S. Ritters Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 120 S. Ritters Lane				120 S. Ritters Lane					
3. NAME OF DECEASED (Type or print) Everett		First	Middle	Last	4. DATE OF DEATH Allen	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1907		9. AGE (In years last birthday) 52 yrs.	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Coast Guard		11. BIRTHPLACE (State or foreign country) Portsmouth, Va		12. CITIZEN OF WHAT COUNTRY? U.S. & U.S.			
13. FATHER'S NAME Howard E Allen		14. MOTHER'S MAIDEN NAME Tira Howard							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		16. SOCIAL SECURITY NO.		17. INFORMANT Address 120 Ritters Lane Owings Mills		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
		147-24-7837		Mrs. Cath. J. Allen		INTERVAL BETWEEN ONSET AND DEATH 15 min.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Prostatectomy						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) none		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. none, 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> none		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE D. D. Caples						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5-25-60	
EXAMINER'S NAME (Type) D. D. Caples, M. D.						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial May 26, 1960 at Baltimore National Cemetery, Baltimore, Md.		22b. DATE THEREOF REMOVED		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or country) (State)			
23. FUNERAL DIRECTOR Frank A. Naylor, Pickwick, Md.						24a. REC'D BY REGISTRAR DATE JUN 7 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kline	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5412

CERTIFICATE OF DEATH

05381

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Harford A. - .	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catoonsville		c. LENGTH OF STAY IN 1b 6yr3mth3cds		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eastport, Maryland		d. STREET ADDRESS 911 Wells Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mabel		First Mabel	Middle Viola	Last Allen	4. DATE OF DEATH Month 5	Day 6	Year 1960
S. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1904		9. AGE (In years last birthday) 56 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Arthur Mason		14. MOTHER'S MAIDEN NAME Eva Mason					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. Unknown		INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X		Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH 4 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Causes Unknown					
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from <u>April 22</u> , 1960, to <u>May 6</u> , 1960, that I last saw the deceased alive on <u>May 5</u> , 1960, and that death occurred at <u>12:10 A.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <i>Edward T. Schnoor</i>		M.D. SPRING GROVE STATE HOSPITAL					
PHYSICIAN'S NAME (Type) Edward T. Schnoor		Catoonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 8-1960		22c. NAME OF CEMETERY OR CREMATORIAL Family Plot		22d. LOCATION (City, town, or county) Deale C. Co Me.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor, Son Amagansett, N.Y.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 9 '60		24b. REGISTRAR'S SIGNATURE <i>Charles S. Knott</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5413

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
Baltimore		MARYLAND 11d.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7		b. COUNTY Baltimore	
c. LENGTH OF STAY IN 1b 7 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6512 Brighton Ave., Baltic 7		d. STREET ADDRESS 6512 Brighton Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Deborah	Middle Lee	Last Anderson
4. DATE OF DEATH	Month May	Day 10,	Year 1960
5. SEX	6. COLOR OR RACE Female	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1952
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Baltimore, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Frederick Henry Anderson	14. MOTHER'S MAIDEN NAME Dorothy Louise Turnbough		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None	16. SOCIAL SECURITY NO None	INFORMANT Mrs. Dorothy L. Anderson, 6512 Brighton Ave.	Baltimore, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ruptured hemangioma - brain</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a),			
INTERVAL BETWEEN ONSET AND DEATH 7 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 3, 1960</i> to <i>May 10, 1960</i> that I last saw the deceased alive on <i>May 3, 1960</i> and that death occurred at <i>5:15 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Clarence E. McWilliams, M.D.</i>	ADDRESS (Street, city or town, state) <i>Reisterstown, Baltimore, Md.</i> DATE SIGNED <i>May 11, 1960</i>		
PHYSICIAN'S NAME (Type) Clarence E. McWilliams	22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial May 12, 1960		
22b. DATE THEREOF May 12, 1960	22c. NAME OF CEMETERY OR CEMETORY Druid Ridge Cemetery	22d. LOCATION (City, town, or county) Pikesville 8, Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank H. Nease, Richardson</i>	ADDRESS <i>1107</i>	24a. REC'D BY REGISTRAR DATE MAY 13 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.



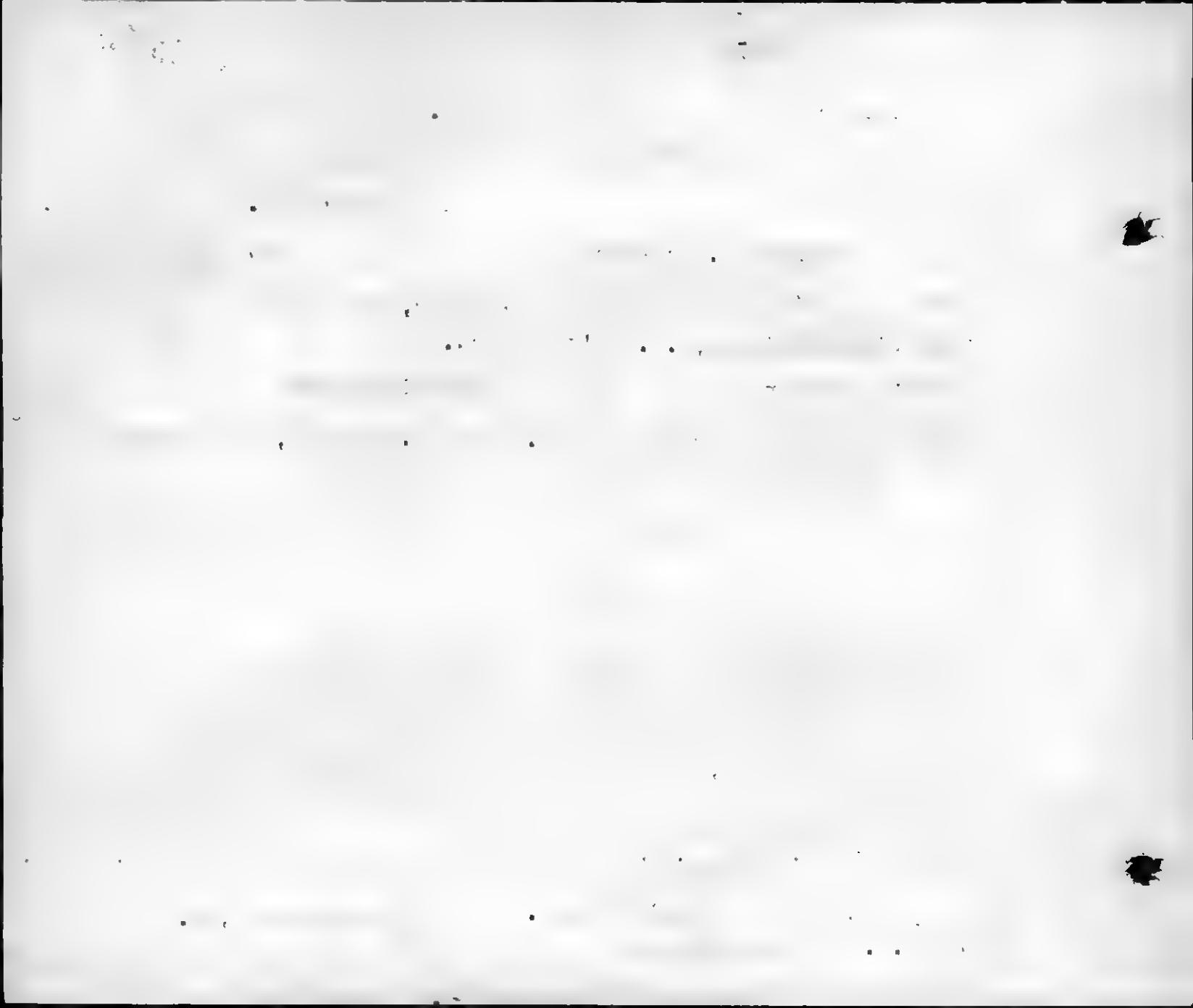
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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 the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 5414 CERTIFICATE OF DEATH

05382

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 20 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		d. STREET ADDRESS 613 Braeside Rd.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 613 Braeside Rd.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Raymond D. Anderson		First	Middle	Last	4. DATE OF DEATH May 30/60	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1893	9. AGE (In years at birthday) 66 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. US/JAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY during most of working life, even if retired) Electrical Engineer, U.S. Gov't		11. BIRTHPLACE (State or foreign country) Ind.		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Robert Anderson		14. MOTHER'S MAIDEN NAME Josephine Weaver						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO WW 1		17. INFORMANT Mrs. Bessie M. Anderson, 613 Braeside Rd		Address Zone 28		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		DUE TO Coronary artery occlusion						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that (I) (this hospital) attended the deceased from April 14, 1956 , to May 30, 1960 , that (I) (we) last saw the deceased alive on May 28, 1960 , and that death occurred at 9:50 AM , from the causes and on the date stated above.								
22a. SIGNATURE 		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5/31/60	
22c. PHYSICIAN'S NAME (Type) Harry L. Knipp, M.D.		22d. ADDRESS 4116 Edmondson Avenue Baltimore, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/2/60		23c. NAME OF CEMETERY OR CREMATORIAL Lorraine Pk.		23d. LOCATION (City, town, or county) Baltimore, Md. (State)		
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101 Edmondson Ave		25a. REC'D BY REG STAR DATE Jun 1 '60						
		25b. REGISTRAR'S SIGNATURE Arthur S. Krause						



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5415

CERTIFICATE OF DEATH

05383

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Dennis Mills		c. LENGTH OF STAY IN 1b X 01 to 07 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Garrison Forrest Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Pauline McElair		First	Middle
4. DATE OF DEATH Month Day Year July 2, 1960		Last	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1873
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) England, U.K.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Samuel McNair		14. MOTHER'S MAIDEN NAME Antoinette Moritz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Richard C. Annan, Garrison Forrest		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ruptured, dissecting aneurysm</i> DUE TO <i>Arteriosclerosis, generalized</i> INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Congestive Heart Failure</i> DUE TO <i>Years</i> (c) <i>Years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June</i> , 1958, to <i>May 2, 1960</i> , that I last saw the deceased alive on <i>May 2, 1960</i> , and that death occurred at <i>6:12 A.M.</i> from the causes and on the date stated above			
ACTUAL SIGNATURE <i>Clarence E. Williams</i>		ADDRESS (Street, city or town, state) <i>11904 Leisterwood, Forest Hill, Md.</i> DATE SIGNED <i>May 2, 1960</i>	
PHYSICIAN'S NAME (Type) <i>Clarence E. Williams</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 22b. DATE THEREOF <i>May 5, 1960</i> 22c. NAME OF CEMETERY OR CREMATORIAL <i>Mountain View Cemetery</i> 22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank J. Jewell, Pickering & Son</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i> DATE MAY 11 '60 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5416

CERTIFICATE OF DEATH

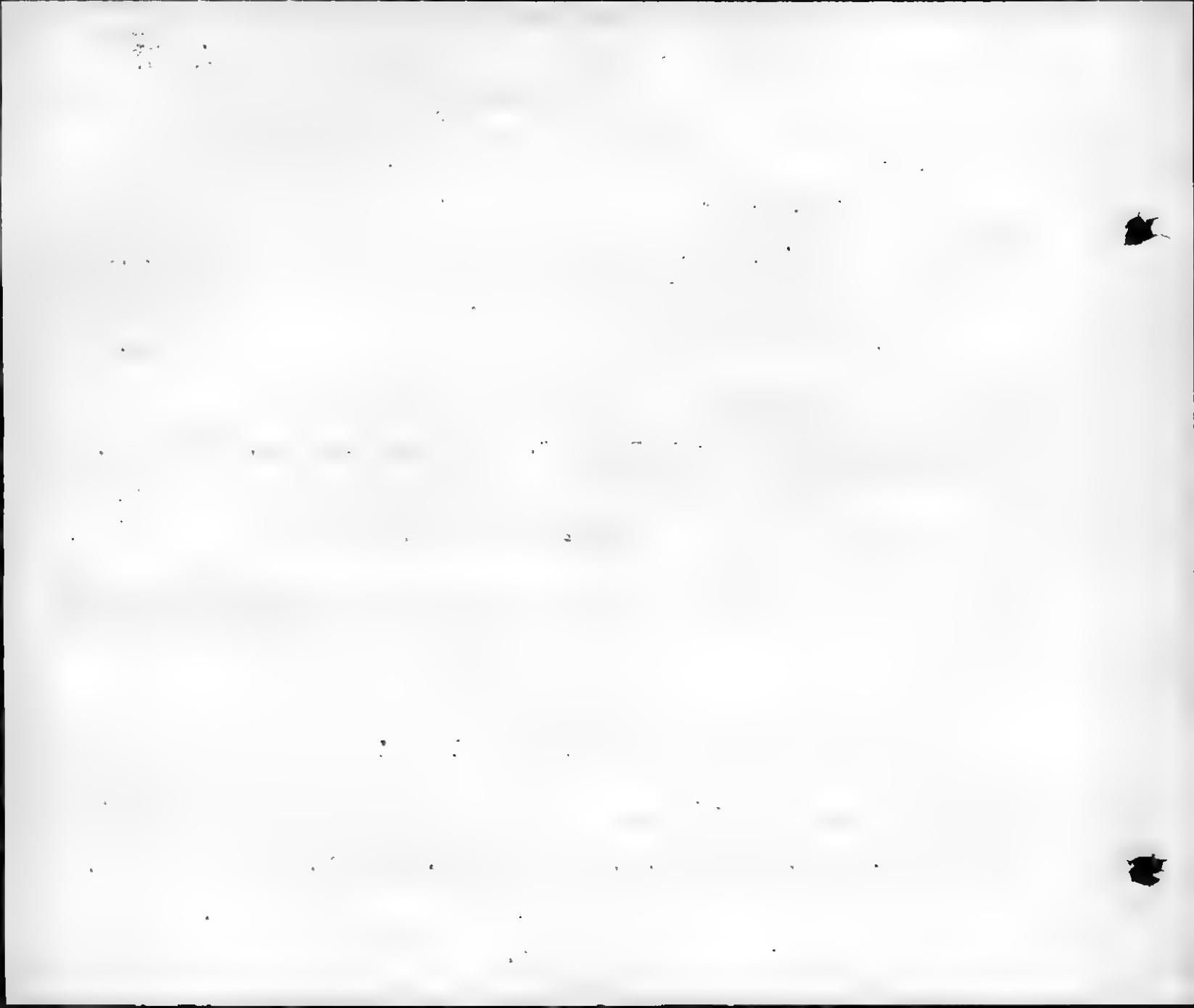
05384

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Granite		c. LENGTH OF STAY IN 1b 14 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> d. STREET ADDRESS Summit Avenue	
3. NAME OF DECEASED (Type or print) Michael Askar	First Michael	Middle 	Last
4. DATE OF DEATH May 16th., 1960	Month May	Day 16	Year 60
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1877
9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman	10b. KIND OF BUSINESS OR INDUSTRY Street Car	11. BIRTHPLACE (State or foreign country) Germany	12. CITIZEN OF WHAT COUNTRY? Germany
13. FATHER'S NAME Andrew Askar	14. MOTHER'S MAIDEN NAME Eleanora Zenk		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 213-14-2120	INFORMANT Mrs. Berta Askar	Address Summit Ave. Granite, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO DUE TO			
CORONARY THROMBOSIS DEGENERATIVE HEART DISEASE INTERVAL BETWEEN ONSET AND DEATH Unknown 5 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 10, 1960 to May 16, 1960 that I last saw the deceased alive on May 13, 1960 , and that death occurred at 4:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Edwin L. Pierpont M.D.			
ACTUAL SIGNATURE		DATE SIGNED 5/17/60	
PHYSICIAN'S NAME (Type) Edwin L. Pierpont M. D.		8204 Liberty Rd. Baltimore - 7, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 19, 1960	22c. NAME OF CEMETERY OR CREMATORIAL St. Alphonsus
22d. LOCATION (City, town, or county) Woodstock, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Baston Sons		24a. REC'D BY REGISTRAR DATE MAY 20 '60	24b. REGISTRAR'S SIGNATURE C. L. Kline

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 days after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

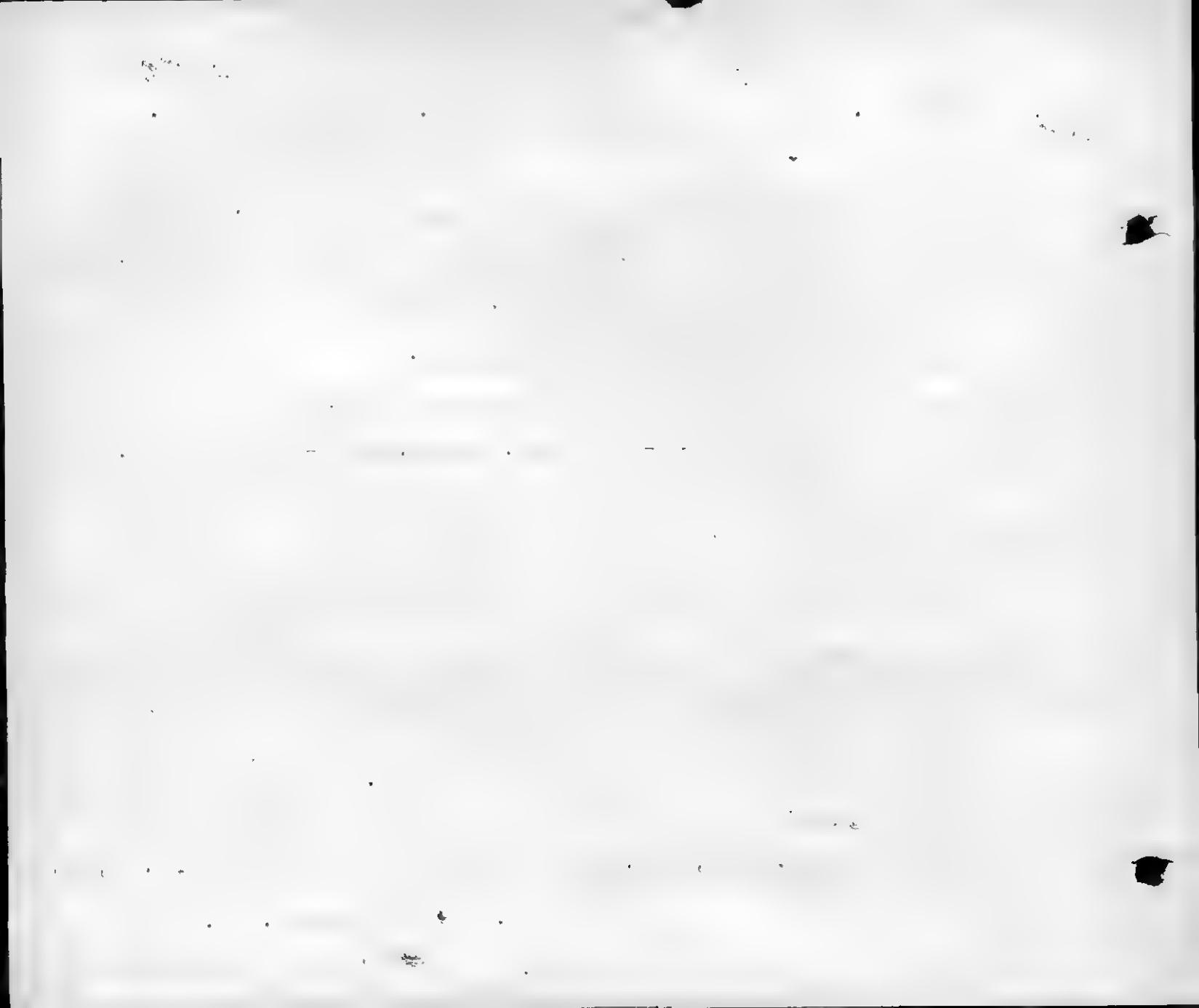
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5417

CERTIFICATE OF DEATH

05385

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 2313 Annapolis Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3325 Offutt Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MAY		First L.	Middle BAGOT	4. DATE OF DEATH Oct. 25, 1882	Month Oct.	Day 25	Year 1882
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1882	9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? Randalls town	
13. FATHER'S NAME Nathan Lilly		14. MOTHER'S MAIDEN NAME Rose Woodward					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-01-8350		17. INFORMANT Mrs. Harry O. Knipp - 3325 Offutt Rd.		Address Randalls town	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 X DUE TO Myocardial Insufficiency INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO Secondary anemia due to severe unexplained astro- intestinal hemorrhage (c) DUE TO Hypertensive arterio-sclerotic cardiovascular disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) 4 (State)	
21. I certify that (I) (this hospital) attended the deceased from June 3, 1950, to May 11, 1960, that (I) (we) last saw the deceased alive on May 11, 1960, and that death occurred at 12:00 P.M. from the causes and on the date stated above		22b. DATE SIGNED May 12, 1960					
22c. SIGNATURE George A. Knipp		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) George A. Knipp, M. D.		22d. ADDRESS 4116 Edmondson Avenue Balto., 26, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/14/60		23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cem.		23d. LOCATION (City, town, or county) Balto. Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Sicker & Sons - Balto. 17, Md.		ADDRESS		25a. REC'D BY REGISTRAR MAY 12 '60		25b. REGISTRAR'S SIGNATURE C. Knipp	
VR A15 (4) 15M 9/59							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

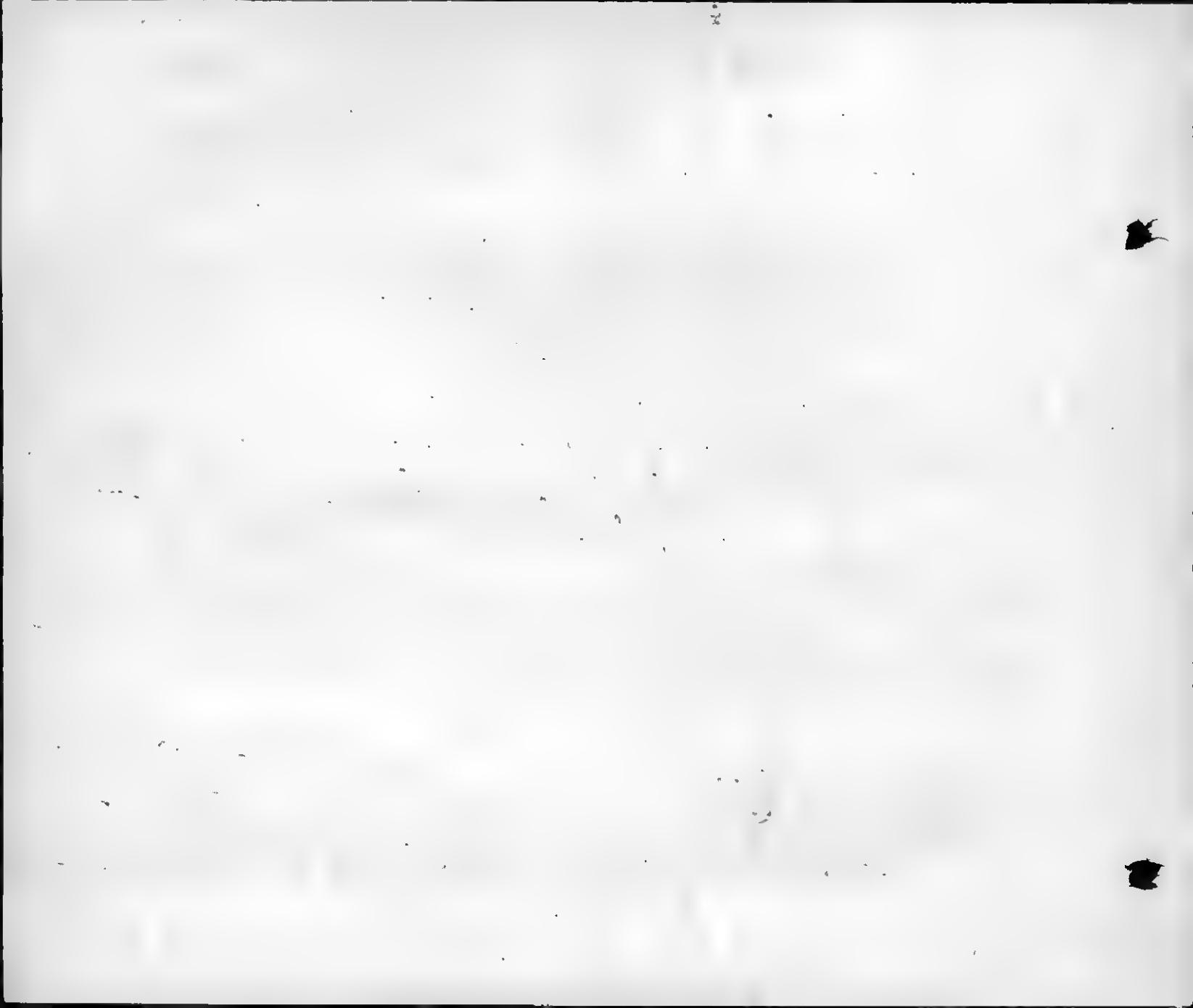
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05386

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>		c. LENGTH OF STAY IN 1b <i>11 month</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>maryland</i>		b. COUNTY		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>College Manor</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Baltimore 12</i>				
						d. STREET ADDRESS <i>601 Anneslie Rd.</i>				
3. NAME OF DECEASED (Type or print)		First <i>Leslie</i>	Middle <i>Wayne</i>	Last <i>Baker</i>	4. DATE OF DEATH <i>May 21 1960</i>	Month <i>May</i>	Day <i>21</i>	Year <i>1960</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>male</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 19 1872</i>		9. AGE (in years last birthday) <i>88 2/2</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Certified Public Accountant</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>				
13. FATHER'S NAME <i>Isaac Baker</i>		14. MOTHER'S MAIDEN NAME <i>Jennie E Moulton</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>813 36 9739</i>		17. INFORMANT <i>Mr. Wendall Baker</i>		Address <i>5803 Kenmore Rd.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Acute Cardiac Failure</i>		DUE TO <i>Arteriosclerosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO <i>Arteriosclerosis</i>		(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)								
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>Dec. 10 1956</i> to <i>May 21 1960</i> , that (I) <i>last</i> saw the deceased alive on <i>May 21 1960</i> , and that death occurred at <i>1042</i> M, from the causes and on the date stated above										
22. SIGNATURE <i>Laurence C. Post</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> 22d. ADDRESS <i>6805 York Rd. Baltimore 12 Md.</i>		STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <i>5-21-60</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>5-24-60</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>PROSPECT HILL</i>		23d. LOCATION (City, town, or county) <i>Towson</i>				
24. FUNERAL DIRECTOR'S SIGNATURE <i>H.W. Jenkins & Sons Co. 4905 York Rd BALTO.</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>MAY 23 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Charles S. Krause</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5419 CERTIFICATE OF DEATH

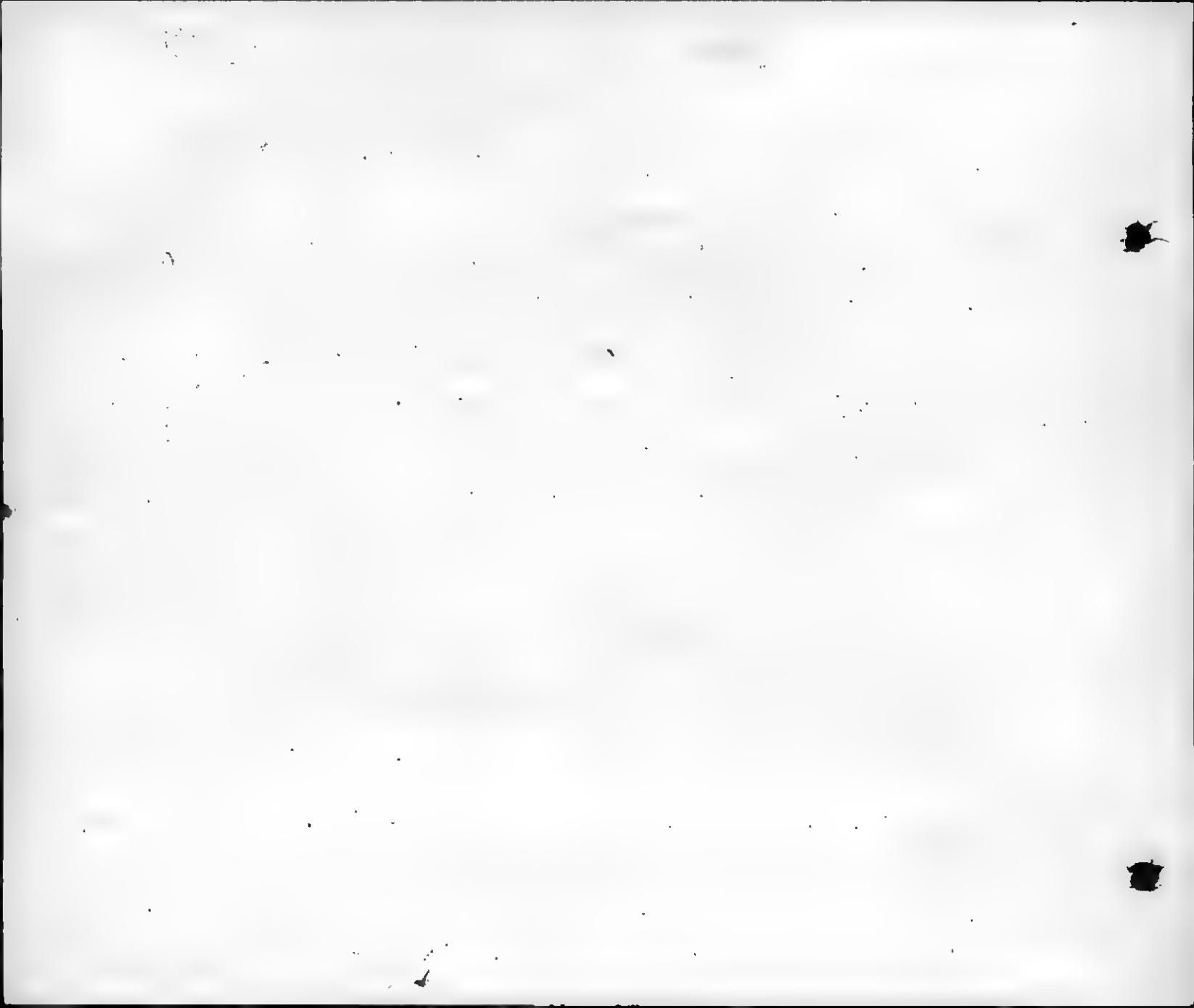
05387

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
<i>Baltimore MARYLAND</i>		<i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
<i>Lutherville</i>		<i>BALTIMORE</i>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>3 yrs</i>		<i>BALTIMORE</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<i>College Manor</i>		<i>1622 Mt. Royal Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<i>Ada</i>	<i>V</i>		<i>Ballard</i>
4. DATE OF DEATH	Month	Day	Year
<i>May</i>	<i>20</i>		<i>1960</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
<i>Female</i>	<i>White</i>	<i>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></i>	<i>Oct. 2, 1869</i>
9. AGE (In years lost birthday)	10. US/AL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>90 yrs</i>	<i>no</i>	<i>Shawan, Maryland</i>	<i>USA</i>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	Address	
<i>George Chilcoat</i>	<i>Josephine Griffith</i>	<i>COLLEGE MANOR HOME LUTHERVILLE MD</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	INTERVAL BETWEEN ONSET AND DEATH
<i>No</i>	<i>NONE</i>	<i>COLLEGE MANOR HOME LUTHERVILLE MD</i>	<i>minute</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
<i>420.1</i>	<i>Coronary thrombosis</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b)	DUE TO	
<i>Coronary atherosclerosis</i>		DUE TO	
		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20c. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
		<i>Hypertension</i>	
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Hour a. m. p. m.		While at work <input type="checkbox"/> at work <input type="checkbox"/>	20f. (City or town) (County) (State)
	<i>19</i>		
21. I certify that I attended the deceased from	<i>Jan</i>	<i>1950</i>	<i>to present</i>
alive on	<i>about May 15</i>	<i>1960</i>	that death occurred at <i>2:50 AM</i> , from the causes and on the date stated above.
ACTUAL SIGNATURE	<i>Ernest Brown Jr</i>		
PHYSICIAN'S NAME (Type)	M.D. <i>401 N. Calvert St</i> ADDRESS (Street, city or town, state) <i>May 29, 1960</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or county)
<i>BURIAL</i>	<i>MAY 23, 1960</i>	<i>LODGE PARK</i>	<i>BALTIMORE, MARYLAND</i>
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<i>HENRY W. JENKINS & Sons</i>	<i>4905 YORK RD BALT 12, MD</i>	<i>DATE</i>	<i>MAY 20 1960</i>

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician and completely filled in by the funeral director.

2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours of death. Page 1 may be signed by the hospital or attending physician. Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with ink. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with ink. The State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

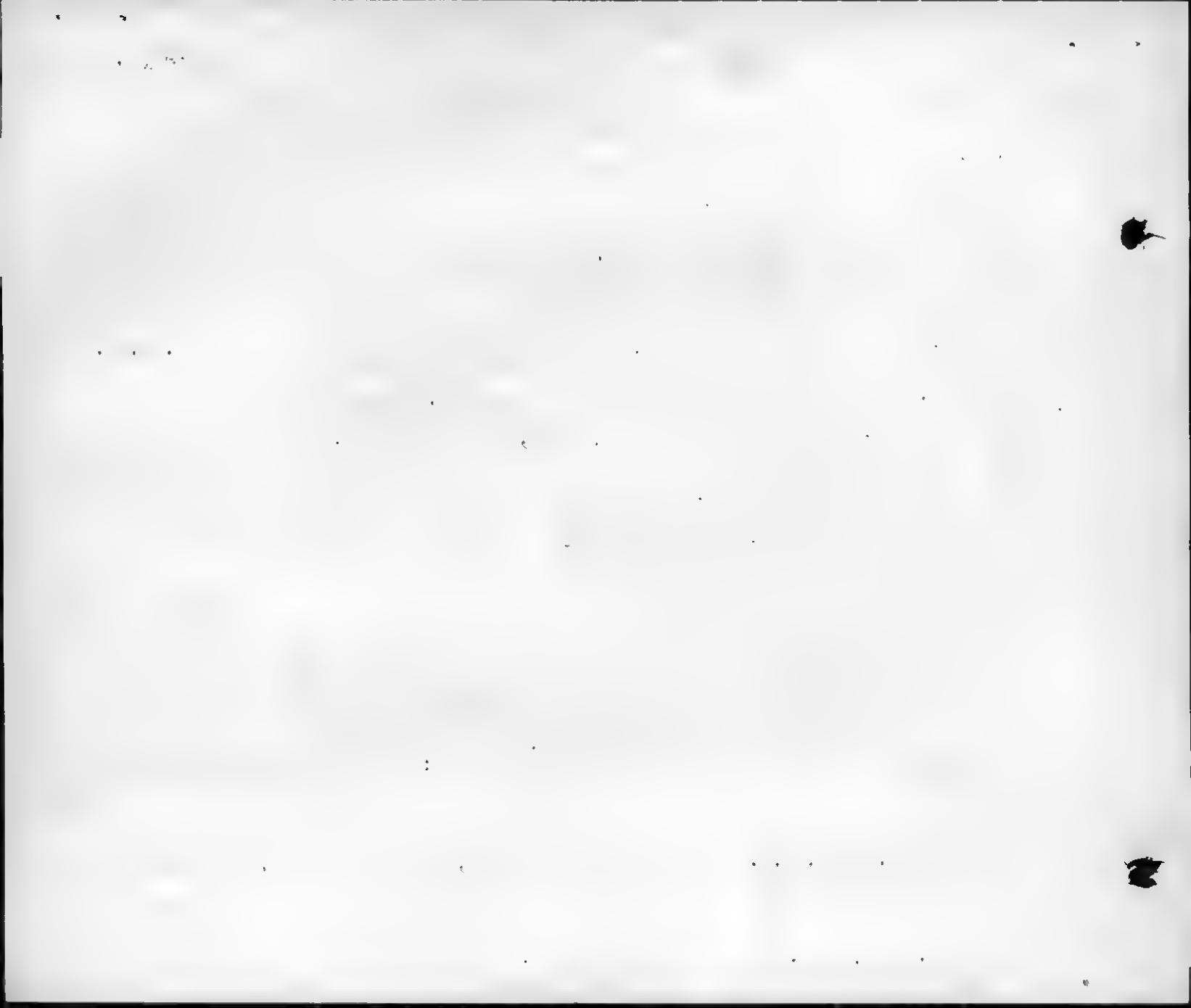
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5420

CERTIFICATE OF DEATH

05388

1. PLACE OF DEATH o COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission) o STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland		c. LENGTH OF STAY IN lb 16 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1004 Williams Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOHN	Middle J.	Last BARNES	4. DATE OF DEATH May	Month May	Day 25	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 11, 1928	9. AGE (In years last birthday) 32	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John J. Barnes							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown)		16. SOCIAL SECURITY NO. WW II 215-22-7610		17. INFORMANT Clinical Records		Address VAH, Baltimore 18, Md. Fort Howard Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EDEMA OF THE LUNGS X RECENT							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) JAUNDICE AND CHRONIC PANCREATITIS X UNKNOWN							
DUE TO PORTAL CIRRHOSIS OF THE LIVER (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) (State) Baltimore Maryland
21. I certify that (s) (this hospital) attended the deceased from May 9 1960 to May 25 1960 , that (I) (we) last saw the deceased alive on May 25 1960 , and that death occurred at p. M. from the causes and on the date stated above							
22a. SIGNATURE <i>Thomas R. Hood</i>							
22b. DATE SIGNED 5/26/60							
22c. PHYSICIAN'S NAME (Type) THOMAS R. HOOD, M.D.							
22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/31/60		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		23d. LOCATION (City, town, or county) Baltimore (State) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John F. Denny Inc. Light & Montgomery Sts. Baltimore, Maryland							
				25a. REC'D BY REGISTRAR DATE MAY 31 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

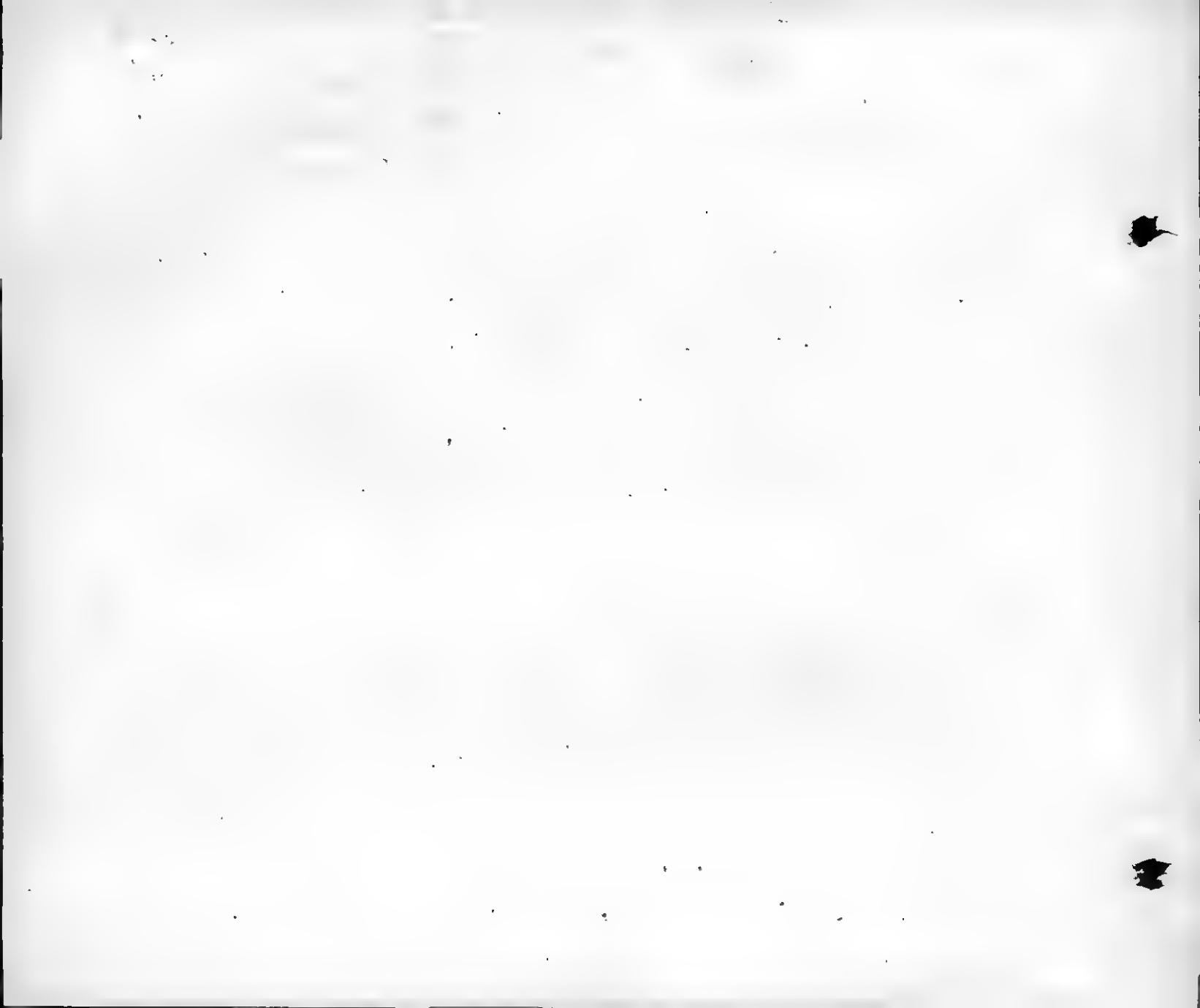
05390

Reg. Dist. No.

CERTIFICATE OF DEATH

5421

1. PLACE OF DEATH o COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 4</u>		c. LENGTH OF STAY IN 1b <u>Baltimore - 4</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1741 Redwood Ave</u>		e. STREET ADDRESS <u>1741 Redwood Ave</u>					
3. NAME OF DECEASED (Type or print) <u>Edward Vernon BATTIN</u>		First	Middle				
		Last					
4. DATE OF DEATH <u>MAY 27 1960</u>		Month	Day				
		Year					
S. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15, 1882</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED EMP.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARTIN CO.</u>					
10c. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>					
13. FATHER'S NAME <u>LEONIDAS A. BATTIN</u>		14. MOTHER'S MAIDEN NAME <u>INDIA BOHLKEN</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-05-93824</u>					
		INFORMANT <u>MRS. IVY BATTIN</u>	Address <u>174 REDWOOD AVE</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>Carcinoma of Stomach</u>							
DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause last. (b) _____							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. <u>19</u> p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg. etc.)		20f. (City or town) <u>6/27</u> (County) <u>6/27</u> (State) <u>1960</u>	
21. I certify that I attended the deceased from <u>6/5, 1960</u> to <u>6/27, 1960</u> , that I last saw the deceased alive on <u>6/27, 1960</u> , and that death occurred at <u>7A</u> M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>5523 York Avenue</u>		DATE SIGNED <u>5/27/60</u>	
ACTUAL SIGNATURE <u>Gorden Grau</u>		PHYSICIAN'S NAME (Type) <u>Gorden Grau, M. D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-30-60</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>PARKWOOD</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Rd.</u>		24a. REC'D BY REGISTRAR <u>May 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Orline S. Kraus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5422 CERTIFICATE OF DEATH

05391
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2 years, 6m.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		d. STREET ADDRESS 216 S. Collington Ave 1980 Rockville ***.	
3. NAME OF DECEASED (Type or print) First Veronica		4. DATE OF DEATH Last Bertch Month May Doy 12 Year 1960	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 9/14/84	
9. AGE (In years less than birthday) 75 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Michael ? Brocki		14. MOTHER'S MAIDEN NAME Katherine ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Acute cardiac failure Arteriosclerotic cardiovascular disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 30, 1959, to May 12, 1960, that I last saw the deceased alive on May 12, 1960, and that death occurred at 1:00a. M, from the causes and on the date stated above. ACTUAL SIGNATURE: <i>Bruno Radauskas</i> ADDRESS (Street, city or town, state) DATE SIGNED M.D. Spring Grove State Hospital 5-12-60			
PHYSICIAN'S NAME (Type)		Bruno Radauskas, M. D. Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/16/1960	
22c. NAME OF CEMETERY OR CREMATORIUM St Stanislaus Cem.		22d. LOCATION (City, town, or county) Baltimore Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Weber & Sons Inc 401 S Chester St		24a. REC'D BY REGISTRAR DATE 5-13-60	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>E. W. Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

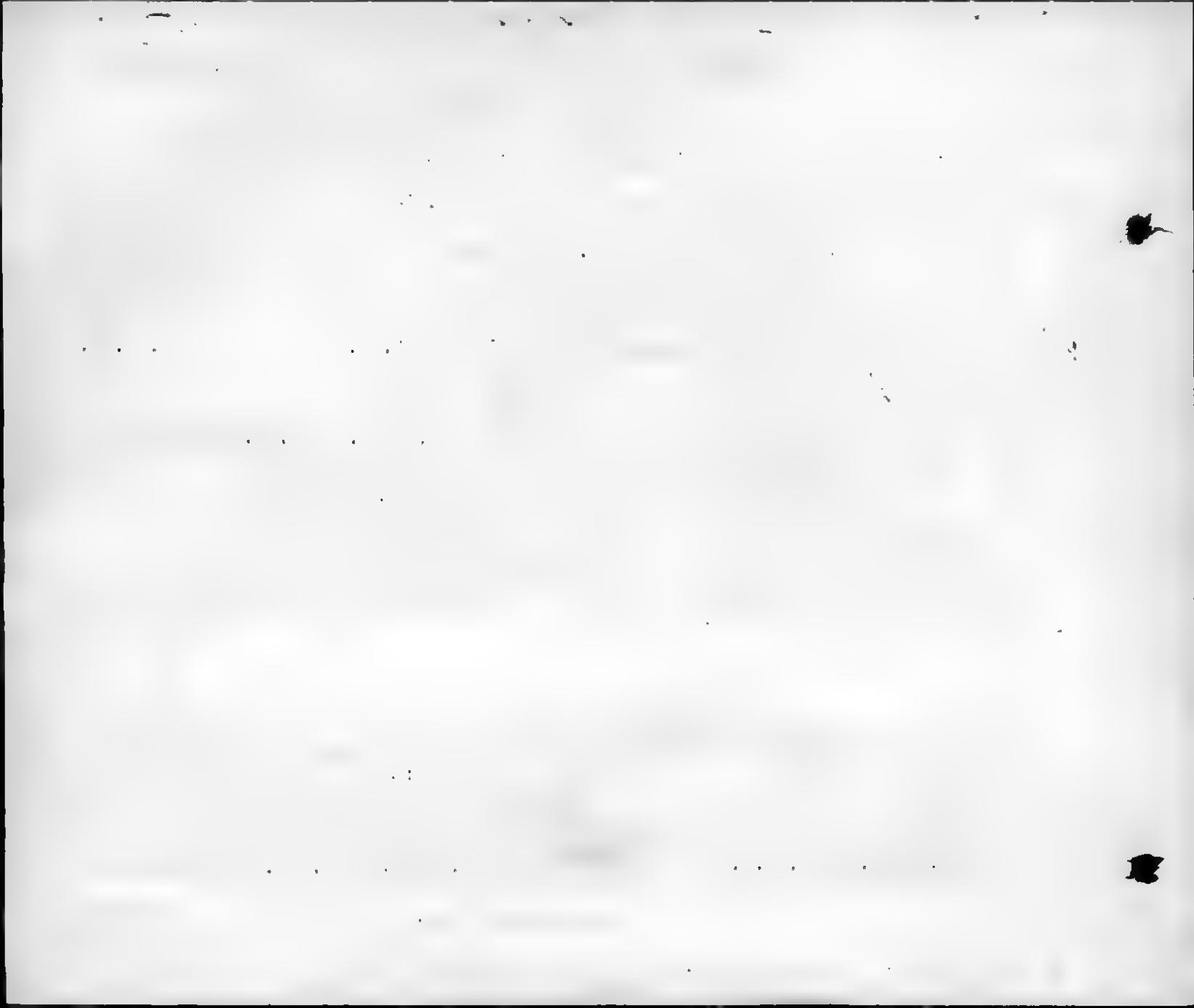
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5423

CERTIFICATE OF DEATH

05392

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 104 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1938 E. Lafayette Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JAMES	Middle D.	Last BETHEA	4. DATE OF DEATH May	Month	Day 22	Year 1960
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 23, 1919	9. AGE (In years last birthday) 40 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Durham, N. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Howard Bethea				14. MOTHER'S MAIDEN NAME Betty McNeill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO WW II		17. INFORMANT Clin/Rec.VAH,BALTO.18,MD.FT.HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF BLADDER WITH REMOTE METASTASES INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 181.0 Conditions, if any, which gave rise to immediate cause (a), stating the under lying cause last. (b) DUE TO (c) DUE TO Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that 1 (this hospital) attended the deceased from February 8, 1960 to May 22, 1960 , that 1 (we) last saw the deceased alive on May 22, 1960 , and that death occurred at 8:00 AM from the causes and on the date stated above							
22a. SIGNATURE <i>Thomas R. Hood</i>				22b. DATE S SIGNED 5/23/60			
22c. PHYSICIAN'S NAME (Type) THOMAS R. HOOD, M.D.		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22d. ADDRESS VAH, BALTO.18, MD. FT. HOWARD DIVISION			
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF 5/25/60		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Baltimore National Cem.		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, 1808 N. Monroe St. Balto. 17, Md.				25a. REC'D BY REGISTRAR MAY 31 '60		25b. REGISTRAR'S SIGNATURE Carroll S. Kraus	

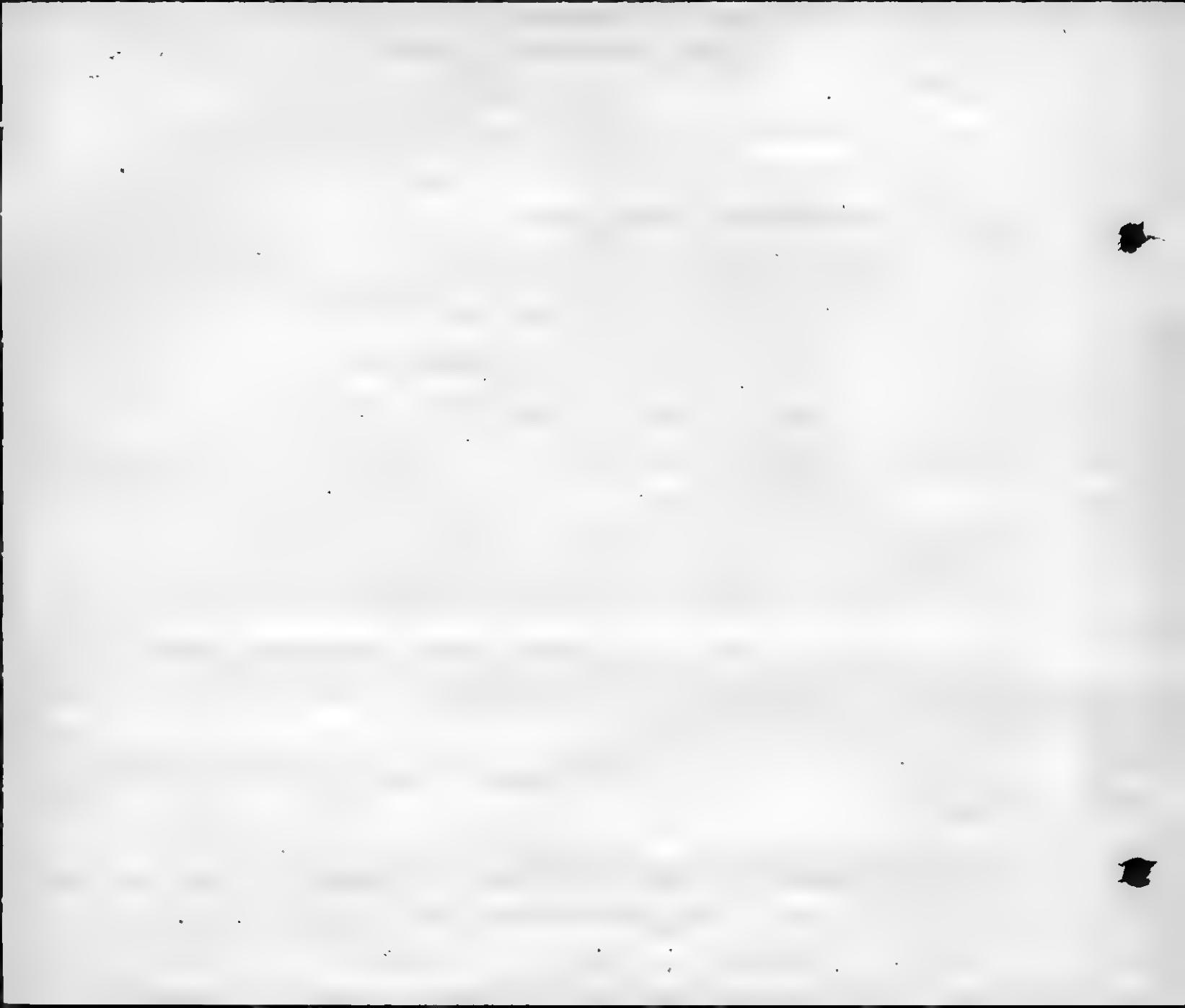


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5424 CERTIFICATE OF DEATH

05393
Reg. Dist. No.

1. PLACE OF DEATH ■ COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Baltimore 22</i>		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Rural Sunnyside</i>	<i>28 yrs</i>	<i>as</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<i>7526 Battle Grove Circle</i>		<i>#1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
	<i>MICHAEL</i>	<i>JOSEPH</i>	<i>BILY</i>
4. DATE OF DEATH	Month	Day	Year
	<i>MAY</i>	<i>5</i>	<i>1960</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
<i>MALE</i>	<i>WHITE</i>		<i>Feb 14. 1892</i>
9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
<i>68</i> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>Clothing mfg.</i>	<i>Taylor</i>	<i>Czechoslovakia</i>	<i>U.S.A.</i>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	Address	
<i>Joseph Bily</i>	<i>Marie Primus</i>	<i>Primus</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	
<i>No</i>	<i>212-16-0213</i>	<i>MARY BILY (WIFE)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
<i>Chronic Glomerulonephritis</i>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			
(b) <i>Diabetes mellitus</i>			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec 8</i> , 1956, to <i>May 5</i> , 1960, that I last saw the deceased alive on <i>May 3</i> , 1960, and that death occurred at <i>620</i> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>Louis N. Tollin</i>		DATE SIGNED <i>5/5/60</i>	
PHYSICIAN'S NAME (Type)		<i>6908 N. Point Rd</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/9/60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Bohemian National Cem</i>
22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Schimunek Funeral Home, Inc.</i>		24a. ADDRESS <i>2601-3-5 E. Madison St.</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Chase</i>
VS A1S (4) 15M 9/55		DATE MAY 9 '60	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. No. 15394

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eccleston		b. COUNTY Baltimore	
c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eccleston	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Park Heights Ave.		d. STREET ADDRESS Park Heights Ave.	
3. NAME OF DECEASED (Type or print) Julia Whitridge		First Julia	Middle Whitridge
		Last Blackford	4. DATE OF DEATH May 5 1960
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1876
9. AGE (In years (1st birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John A. Whitridge		14. MOTHER'S MAIDEN NAME Ellen Henderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Bartlett F. Johnston Eccleston, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) complete Heart block. A-V dissociation 2 months. DUE TO (c) arterio sclerosis		INTERVAL BETWEEN ONSET AND DEATH 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Mar 7 , 1947 to May 5 , 1960, that I last saw the deceased alive on May 4 , 1960, and that death occurred at 5 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 1725 Reisterstown Rd. DATE SIGNED Pikesville B. Md.	
ACTUAL SIGNATURE Palmer F. Williams		PHYSICIAN'S NAME (Type) Palmer F. Williams	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-7-60	22c. NAME OF CEMETERY OR CREMATORIAL Greenmount
22d. LOCATION (City, town, or county) Baltimore		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co.		24a. ADDRESS 4905 York Rd.	24b. REC'D BY REGISTRAR DATE MAY 6 '60
			24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



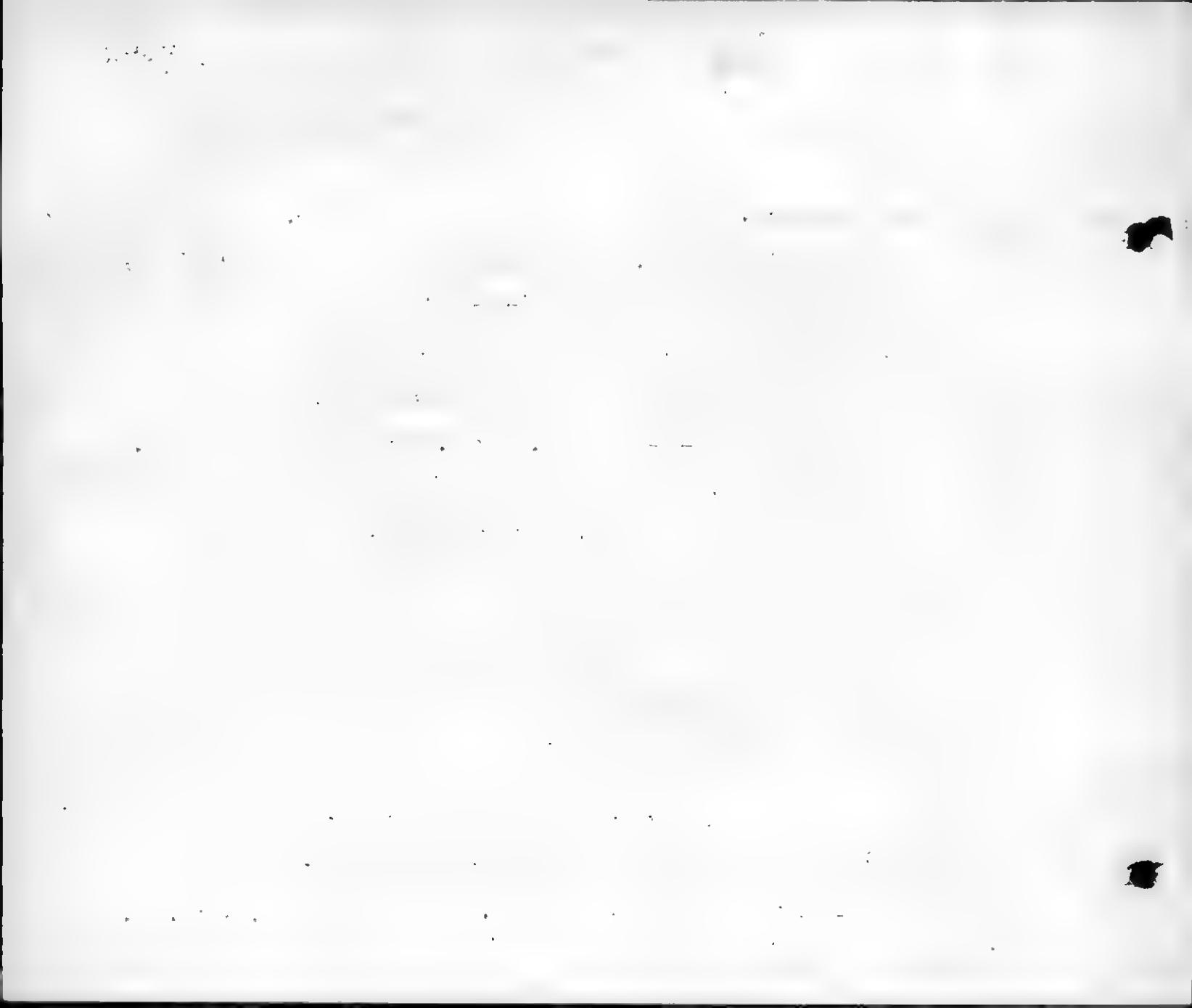
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05395

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6805 Beech Ave.		e. STREET ADDRESS 6805 Beech Ave.	
3. NAME OF DECEASED (Type or print) John L. Bodenschatz		First John	Middle L.
4. DATE OF DEATH May 8, 1960		Last Bodenschatz	Month May
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Construction
8. DATE OF BIRTH 11-22-1879		9. AGE (In years last birthday) 80 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Karl Bodenschatz		14. MOTHER'S MAIDEN NAME Margareta Geyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-09-2944	
17. INFORMANT Mrs. Anna M. Hobbs		Address 4601 Ridgeway Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 1 HOUR	
DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		10 YEARS	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 17, 1955 , to May 8, 1960 , that I last saw the deceased alive on April 26, 1960 , and that death occurred at 2 P. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 6732 BELAIR RD., BALTIMORE 6, MD.	
ACTUAL SIGNATURE Adam G. Swiss		DATE SIGNED May 9, 1960	
PHYSICIAN'S NAME (Type) ADAM G. SWISS		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-12-1960	
22c. NAME OF CEMETERY OR CREMATORIAL Jerusalem Lutheran		22d. LOCATION (City, town, or county) (State) Belair Rd., Belair, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lorraine F. Hobbs		ADDRESS 7401 Belair Rd.	
		24a. REC'D BY REGISTRAR MAY 10 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



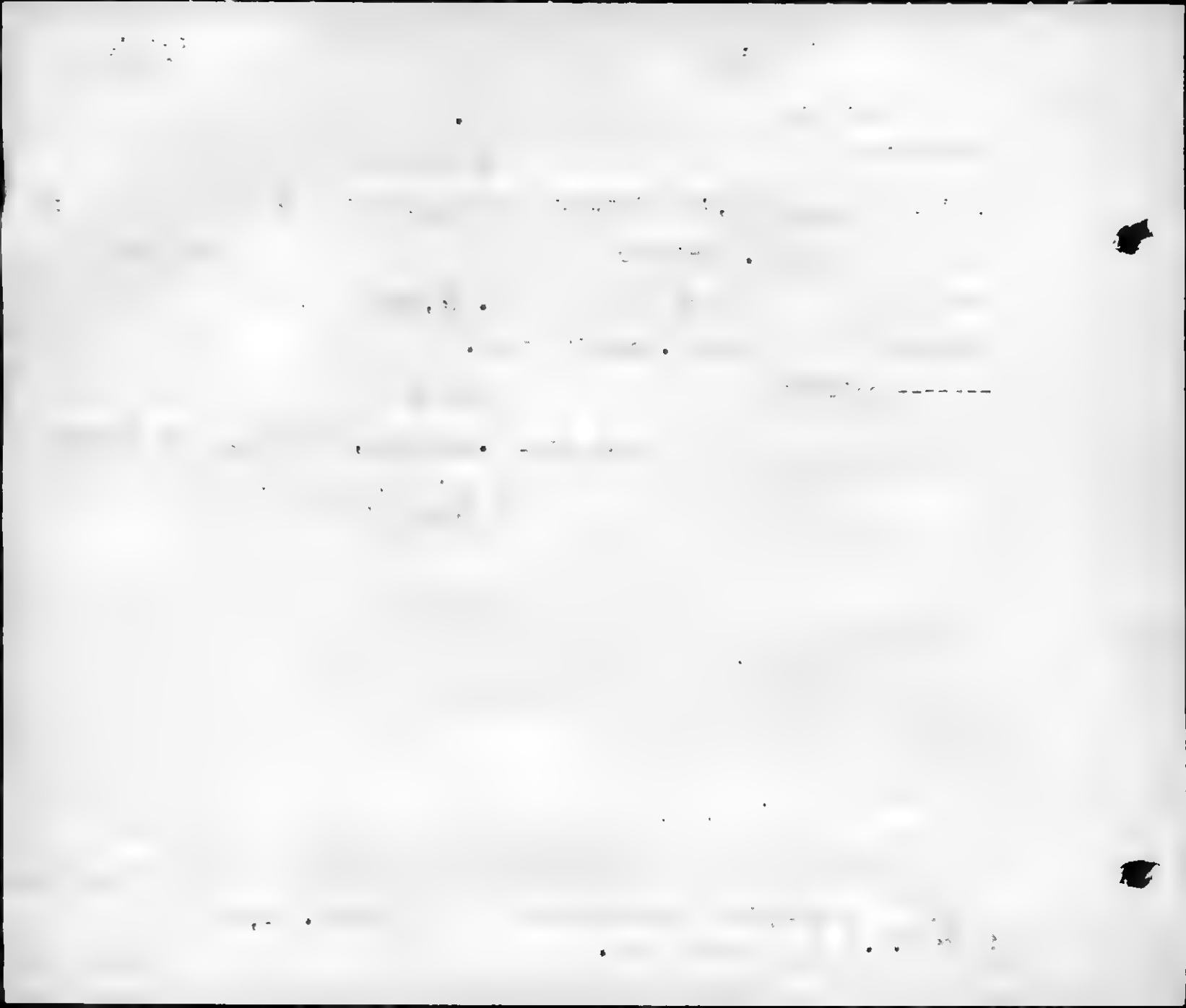
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5427

CERTIFICATE OF DEATH

05396

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summitt Nursing Home, 98 Smithwood		4. STREET ADDRESS Ave 1252 Maple Ave			
3. NAME OF DECEASED (Type or print) John C. Bonicker		First John	Middle C.		
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 12, 1884		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Balto. Transit Co	11. BIRTHPLACE (State or foreign country) Md.		
13. FATHER'S NAME -----Bonicker		14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. 213 10 2591	17. INFORMANT Paul V. Bonicker, 1252 Maple Ave Arbutus		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Meningitis & Meningo/ Abscess Cervical Arter.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Editha Foley Services Attd. Perubitus Ulcers</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>5/21/60</i>	20f. (City or town) <i>5/25/60</i>	(County) <i>5/25/60</i>	(State) <i>5/25/60</i>
21. I certify that (I) (this hospital) attended the deceased from <i>5/18/60</i> to <i>5/25/60</i> , that (I) (we) last saw the deceased alive on <i>5/18/60</i> , and that death occurred <i>5/25/60</i> from the causes and on the date stated above.					
22a. SIGNATURE <i>John C. Bonicker</i>		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>W.E. McGrath M.D.</i>		22d. ADDRESS <i>1303 Frederick Rd</i>			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF May 28/60	23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park	23d. LOCATION (City, town, or county) <i>Balto. 29 Ma</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Witzke F.D. 4101 Edmondson Ave.</i>		25a. REC'D BY REGISTRAR Arthur S. Kraus		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
		DATE MAY 31 '60			

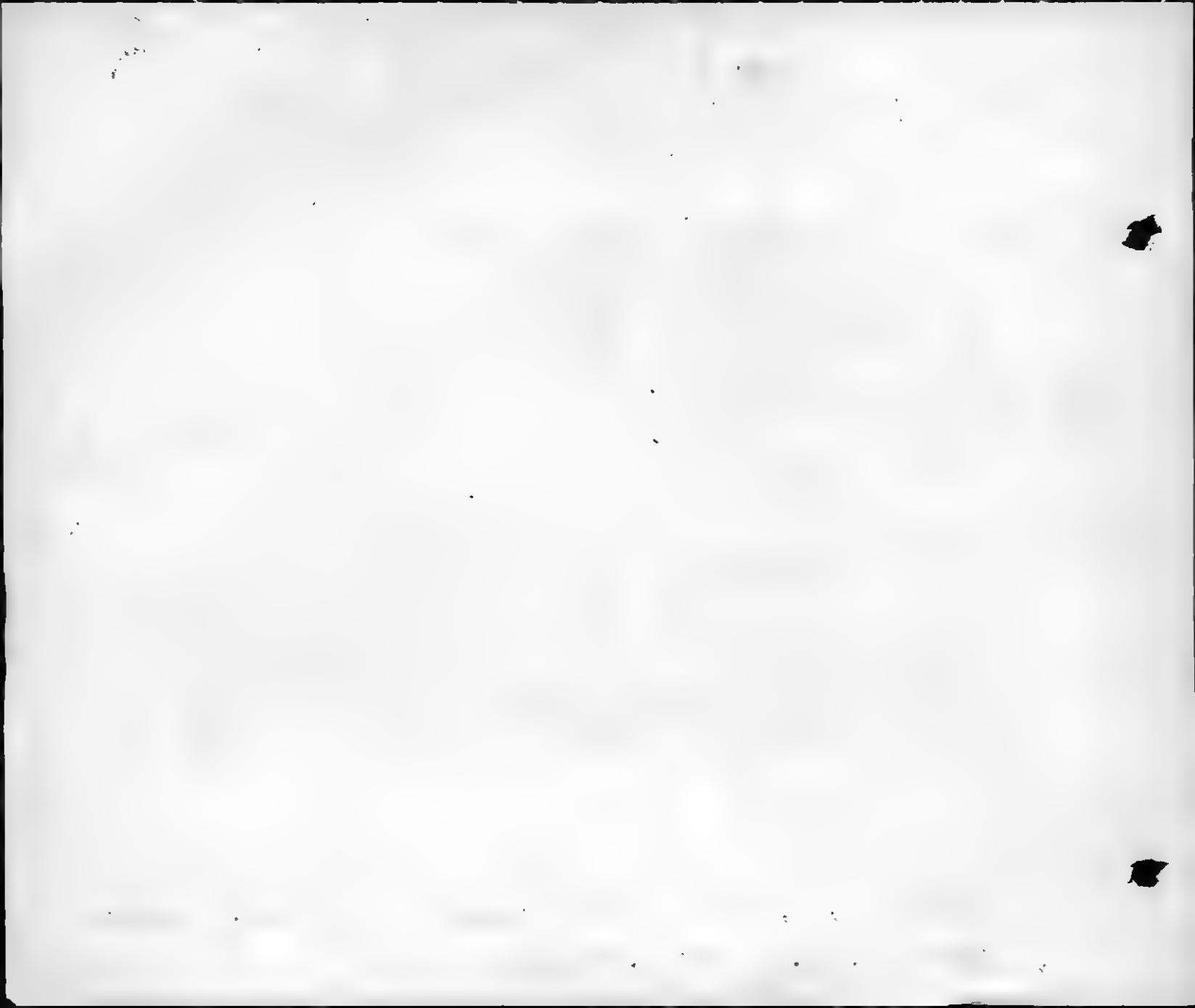


MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5428 05397

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 8 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JANE	Middle BOOTH	4. DATE OF DEATH MAY 20 1960
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-16-1872
9. AGE (In years last birthday) 87	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U. S
13. FATHER'S NAME CHARLES W. RUTLEDGE	14. MOTHER'S MAIDEN NAME JANE POOLE		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Frank L. Smith Jr. - Cockeysville, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
Anterior Arteriole Cardia Vascular Disease			INTERVAL BETWEEN ONSET AND DEATH 8 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-16-1952 to 5-20-1960 , that (I) (we) last saw the deceased alive on 5-20-1960 , and that death occurred at 530 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Walter T. Kees	M.D.	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5/20/60
22c. PHYSICIAN'S NAME (Type) WALTER T. KEE	22d. ADDRESS COCKEYSVILLE MD.		
23a. BURIAL CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF May 24, 1960	23c. NAME OF CEMETERY OR CREMATORIAL Baltimore Cemetery	23d. LOCATION (City, town, or county) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc.	ADDRESS 1217 St. Paul Street	25a. REC'D BY REGISTRAR MAY 24 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Kress



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5429 CERTIFICATE OF DEATH

05398

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3 V 0 1 . 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 856 West Baltimore Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRED		First MIDDLE FRED C.		Last BOYD		4. DATE OF DEATH May	Month Day Year 18 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 31, 1905		9. AGE (In years last birthday) 55 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY Shipyards		11. BIRTHPLACE (State or foreign country) Whittier, N. Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Boyd		14. MOTHER'S MAIDEN NAME Maggie Carver					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WW II		17. INFORMANT Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE (c) DIVERTICULITIS INTERVAL BETWEEN ONSET AND DEATH SUDDEN UNKNOWN 3 DAYS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from May 16 1960 to May 18 1960, that (1) (we) last saw the deceased alive on May 18 1960, and that death occurred at A M, from the causes and on the date stated above.							
22a. SIGNATURE John D. Talbert, M.D.		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE 5/18/60			
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.							
23a. BURIAL, CREMATION, BURIAL (Specify) Burial		23b. DATE THEREOF 5/20/60		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cem.		23d. LOCATION (City, town, or county) Baltimore, Maryland (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home, 2601 E. Madison St.				ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 20 '60	25b. REGISTRAR'S SIGNATURE Cathleen S. Thomas



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5430

CERTIFICATE OF DEATH

05399

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: This requires that this death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH Rosewood State Training School
a. COUNTY Baltimore MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland

c. LENGTH OF STAY IN 1b 4 months

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Maryland b. COUNTY City

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30, Maryland

d. STREET ADDRESS 646 W. Barre Avenue

e. IS RESIDENCE ON A FARM? YES NO

3. NAME OF DECEASED (Type or print) First Middle Last
Charles Junior Bradford

4. DATE OF DEATH Month Day Year
5 26 19 60

5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 8/9/59
WIDOWED DIVORCED

9. AGE (In years lost birthday) yrs. 9 Months Days Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?

Maryland, Baltimore U.S.A.

13. FATHER'S NAME Charles Bradford 14. MOTHER'S MAIDEN NAME Dorothy Mary Frances Carter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. INFORMANT Address
no — Rosewood Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Severe Non-Compensated Hydrocephalus (increased 344)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) intracranial pressure) 4/19/60
DUE TO (c) Anemia 3 weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year (County) (State)
Hour a. m. 19 20d. INJURY OCCURRED White Not white
p. m. of work of work 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town)

21. I certify that I attended the deceased from 1/25/60, 19, to 5/26/60, 19, that I last saw the deceased alive on 5/26/60, 19, and that death occurred at 11:55 P.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

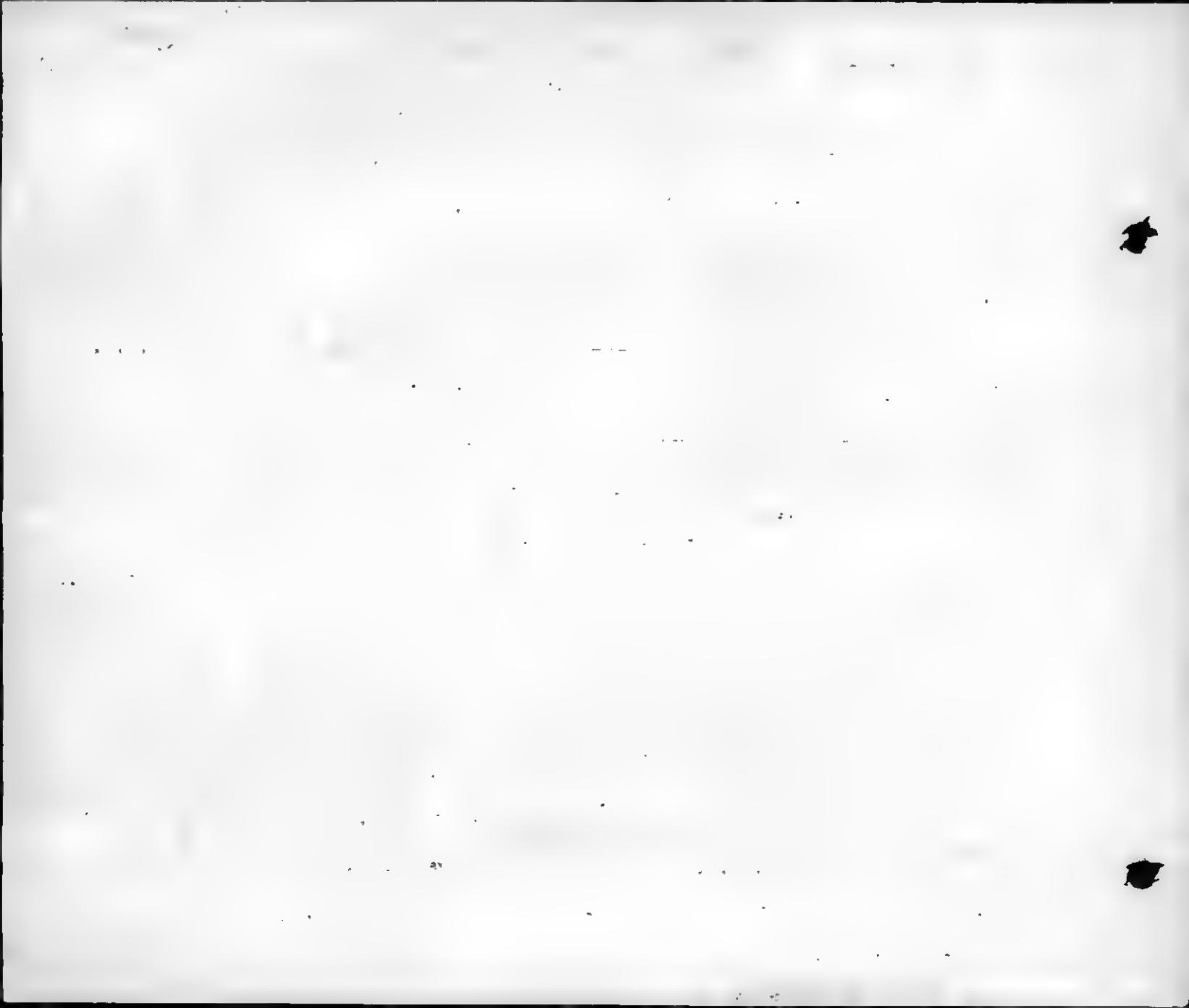
DATE SIGNED

ACTUAL SIGNATURE 20 Jun 1960 M.D. Rosewood Tr. School 5/27/60

PHYSICIAN'S NAME (Type) John Pappas, M.D. Owings Mills, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL (State)
Burial 5/21/60 Mt. Calvary Cem. Cedar Hill, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE
E. S. Wilson 1000 Bryant Ave. DATE JUN 2 '60 Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5431 CERTIFICATE OF DEATH

05400

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <i>Baltimore Co.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparrows Point</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparrows Point</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1007 J. St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>John Willie Brooks Jr.</i>		4. DATE OF DEATH <i>May 25, 1960</i>	Month Day Year
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>June 24 1896</i>		9. AGE (In years, last birthday) <i>63 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labors</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Steelworks</i>	11. BIRTHPLACE (State or foreign country) <i>Atlanta Ga.</i>
13. FATHER'S NAME <i>John Willie Brooks</i>		14. MOTHER'S MAIDEN NAME <i>Addie</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>Woud War</i>	17. INFORMANT <i>Helen C. Brooks 1007 J. St Sparrows B.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420</i>		DUE TO <i>Coronary occlusion</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>hypertension</i>		DUE TO <i>Hypertension</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 20) <i>injury</i>	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>January 17 1960</i> to <i>May 25 1960</i> , that I last saw the deceased alive on <i>May 25 1960</i> , and that death occurred at <i>7 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. H. Thomas</i>		ADDRESS (Street, city or town, state) <i>107 N. Main St. Baltimore 22</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 25 1960</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore Natl. Cem.</i>
22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank J. Eickson</i>	
24a. REC'D BY REGISTRAR DATE <i>MAY 27 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5432 CERTIFICATE OF DEATH 05401

1. PLACE OF DEATH a. COUNTY BALTIMORE		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b 55		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY BALTIMORE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15 - HILLSIDE AVE.		d. STREET ADDRESS 115 HILLSIDE AVE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MARIE		First W.	Middle W.	Last BRUFF	4. DATE OF DEATH MAY 31 1960	Month MAY	Day 31	Year 1960			
S. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 9 1890	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME JACOB WOHLGEMUTH		14. MOTHER'S MAIDEN NAME MARGARET GERHOLD									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. Carl Bruff (Son) 15 HILLSIDE AVE		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH of year									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420 00		DUE TO Arteriosclerotic heart disease									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b)		DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) NOV 3 1955 to May 31 1960		(County) Jan 2, 1960		(State)	
21. I certify that (1) (this hospital) attended the deceased from NOV 3 1955 to May 31 1960 , that (2) I last saw the deceased alive on May 27 1960 , and that death occurred at 12 M from the causes and on the date stated above.											
22a. SIGNATURE A. S. Chalfant Jr.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED Jan 2, 1960			
22c. PHYSICIAN'S NAME (Type) Dr. A. S. CHALFANT		22d. ADDRESS 6210 York Rd, Baltimore, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JUNE 3, 1960		23c. NAME OF CEMETERY OR CREMATORIUM PARKWOOD CEMETERY		23d. LOCATION (City, town, or county) BALTIMORE COUNTY, MD.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins & Sons Co.		ADDRESS 4905 York Rd, Bldg 12		25a. REC'D BY REGISTRAR Jan 2 '60		25b. REGISTRAR'S SIGNATURE Charles & Anna					



1
FOR STATE
HEALTH DEPT.

M

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5388

15482

1. PLACE OF DEATH
a. COUNTY

Baltimore

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Dundalk

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

8000 Mid-Haven Road

MARYLAND

c. LENGTH OF STAY IN HB

Life

3. NAME OF
DECEASED
(Type or print)

JOSEPH Frank BUCZKOWSKI

First Middle Last

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

Dec. 6, 1923

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Shear Operator

10b. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel

11. BIRTHPLACE (State or foreign country)

CBalto. Md.

13. FATHER'S NAME

Joseph Buczkowski

14. MOTHER'S MAIDEN NAME

Mary E. Sewell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and years of service)

Yes W.W.II

16. SOCIAL SECURITY NO.

17. INFORMANT

219-14-0313 Audrey E. Grabarek 609 S. Robinson St.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Stab Wound of Chest.

INTERVAL BETWEEN
ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

DUE TO

(d)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

Stabbed during altercation.

20c. TIME OF INJURY Month, Day, Year
Hour a.m.

May 30 60

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

House

Dundalk

Baltimore

Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

MEDICAL
SIGNATURE

EXAMINER'S
NAME (Type)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

6/3/60

22c. NAME OF CEMETERY OR CREMATORIAL

Balto. National

22d. LOCATION (City, town, or country)

Balto. Md.

23. FUNERAL DIRECTOR.

Wm. S. Falkowski

ADDRESS

2007 Eastern Ave

24a. REC'D BY REG. STRR.

JUN 1 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. Krause

MEDICAL CERTIFICATION

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

5/31/60

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5433 CERTIFICATE OF DEATH

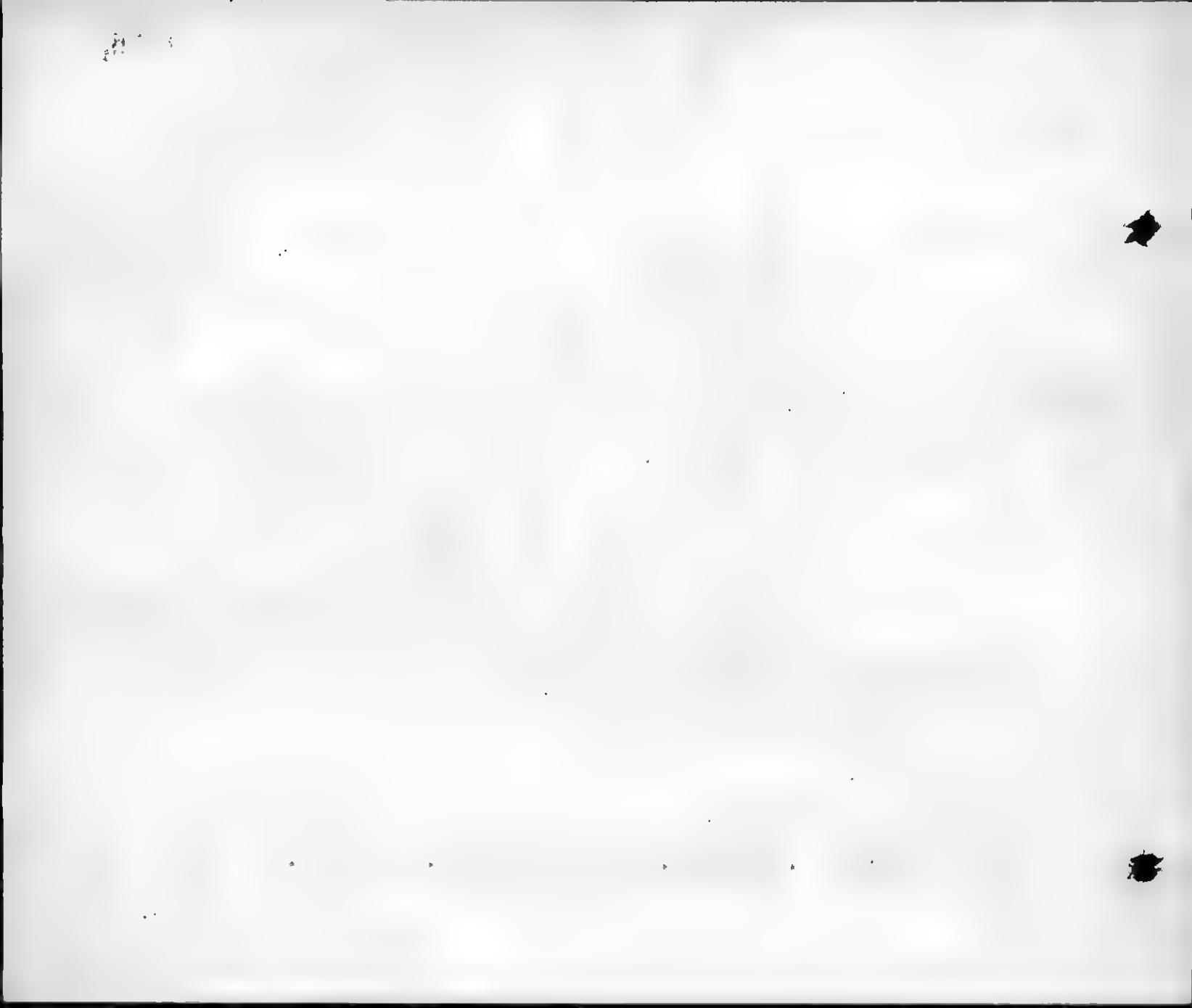
05404

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
BALTIMORE MARYLAND		c. LENGTH OF STAY IN 1b RURAL and give nearest town)	
b. CITY OR TOWN (If outside corporate limits, write Lutherville.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Collegiate Manor		d. STREET ADDRESS 3369 Devon Rd	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
4. DATE OF DEATH		Month	Day
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR (If UNDER 24 HRS Months Days Hours Min)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John B. Berger		14. MOTHER'S MAIDEN NAME Wilhelmina Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO None	
17. INFORMANT DR. T. TERRY BURGER 116 E MELROSE AVE.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Central thrombosis		~7 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO Central arteriosclerosis		yrs -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Branches pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>60</u> , to <u>Present</u> , 19 <u> </u> , that I last saw the deceased alive on <u>May 20</u> , 19 <u>60</u> , and that death occurred at <u>2:50</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Ernest C. Brown Jr. M.D. 1101 N. Calvert St, Baltimore, MD 21202	
ACTUAL SIGNATURE		DATE SIGNED 5/20/60	
PHYSICIAN'S NAME (Type)		1101 N. Calvert St.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-23-60	22c. NAME OF CEMETERY OR CREMATORIAL LOUDON PARK
22d. LOCATION (City, town, or county) BALTIMORE, MARYLAND		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN O. MITCHELL & SONS, INC., 1900 EUTAW Pl.		24a. REC'D. BY REGISTRAR MAY 23 60	24b. REC'D. BY REGISTRAR'S SIGNATURE Albert S. Evans
ADDRESS		DATE	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5434 CERTIFICATE OF DEATH

05403
Reg. Dist. No.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY		Baltimore Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		a. STATE Md		b. COUNTY BALTO CITY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN TB TOWSON 8 MONTHS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		BALTO CITY (10)		28-1-11					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Sheppard and Enoch Pratt Hosp.		e. IS RESIDENCE ON A FARM?		635 Colorado Ave		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
ELLA		COLEMAN		BURLESON	MAY	28	1960						
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years from birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min					
F		W		AUG 31 1878		Months	Days	Hours	Min				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY				
HOUSEWIFE			—			MARYLAND			US				
13. FATHER'S NAME MARIE JEROME PENDERGAST					14. MOTHER'S MAIDEN NAME ELLA COLEMAN								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO.					Address			
17. INFORMANT					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					INTERVAL BETWEEN ONSET AND DEATH			
—					PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA					7 days			
476 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.					(b) Generalized Arterosclerosis, Arteriosclerosis Heart Disease					5 years.			
DUE TO													
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					chronic Brain syndrome					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 12, 1959 to 28 May, 1960, that I last saw the deceased alive on 27 May, 1960, and that death occurred at 3:17 AM, from the causes and on the date stated above.										ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE		Harry M. Murdock, M.D.			Sheppard & Enoch Pratt Hosp			28 May 1960					
PHYSICIAN'S NAME (Type)		HARRY M MURDOCK			TOWSON 4 MD								
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM			22d. LOCATION (City, town, or county)		(State)				
burial		5-31-60		NEW CATHEDRAL			BALTO.		MD				
23. FUNERAL DIRECTOR'S SIGNATURE					ADDRESS					24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
H W Jenkins & Sons Co. 4905 York Rd BALTO.					DAKIN 2 '60					Arthur S. Kraus			



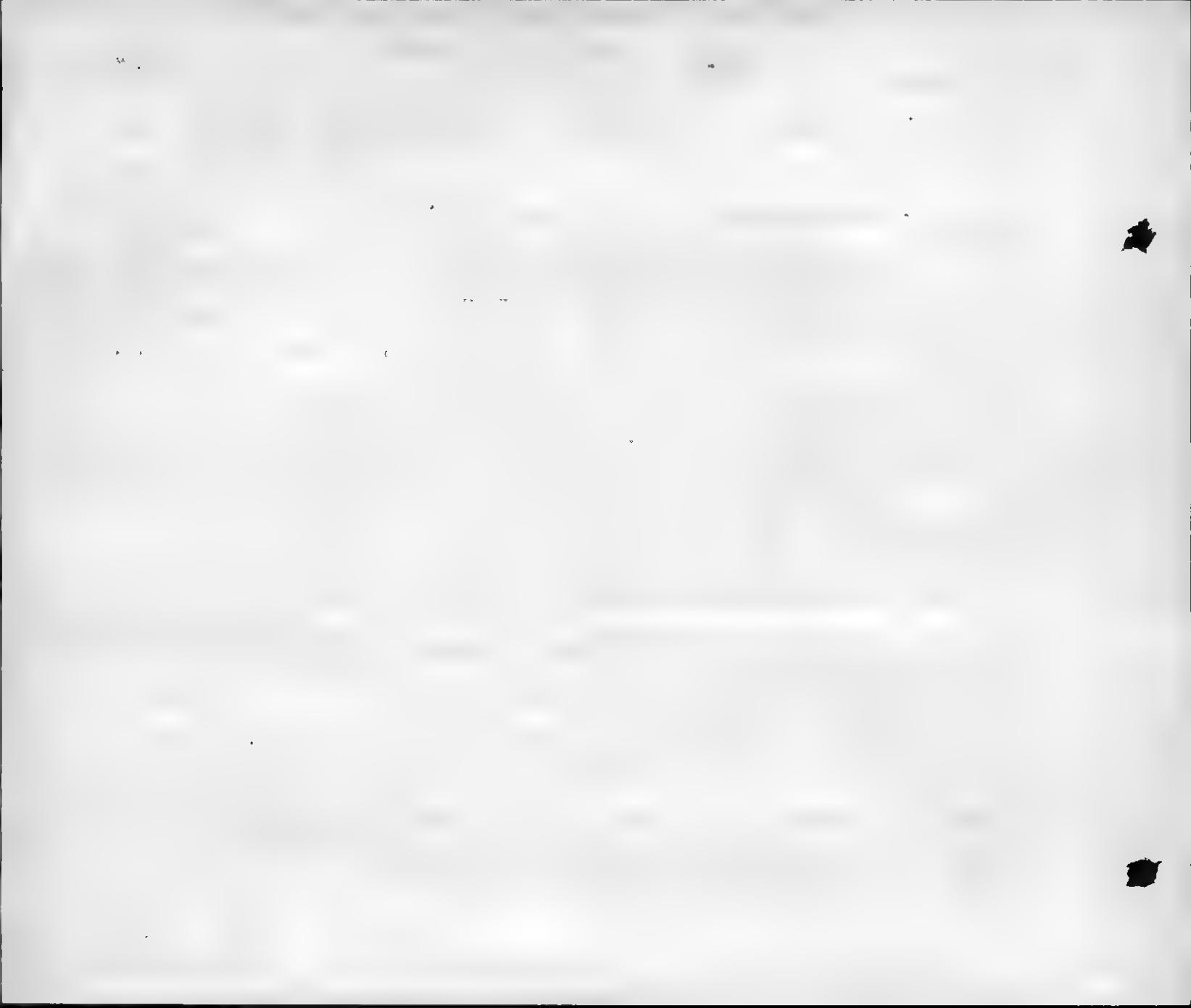
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5435

CERTIFICATE OF DEATH

Reg. No. 05405

1. PLACE OF DEATH o. COUNTY Baltimore.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14		d. STREET ADDRESS 528 W. Mulberry Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Ella	Middle Genevieve	Last Cannon	4. DATE OF DEATH May 10	Month May	Day 10	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-26-1875	9. AGE (In years lost birthday 84 yrs.)	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer		10b. KIND OF BUSINESS OR INDUSTRY Panama Factory		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Cannon		14. MOTHER'S MAIDEN NAME Margaret Dougherty					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tel. no. or, unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 215-03-9256		17. INFORMANT Mrs. MARY B. GEPPI		Address 530 W. MULBERRY	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X		DUE TO Nephritis chronic		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) (c)		DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 5, 1960 to May 10, 1960 , that I last saw the deceased alive on May 9, 1960 , and that death occurred at 4:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Charles F O'Donnell</i>		ADDRESS (Street, city or town, state) 7501 York Rd - Towson 5-6060		DATE SIGNED 5-13-60			
PHYSICIAN'S NAME (Type) Charles F O'Donnell M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/12/60		22c. NAME OF CEMETERY OR CREMATORIAL Green Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Walter Kirkland 5444 Belair Rd</i>		ADDRESS J. Walter Kirkland 5444 Belair Rd		24a. REC'D BY REGISTRAR DATE MAY 13 '60		24b. REGISTRAR'S SIGNATURE Charles S. Krause	



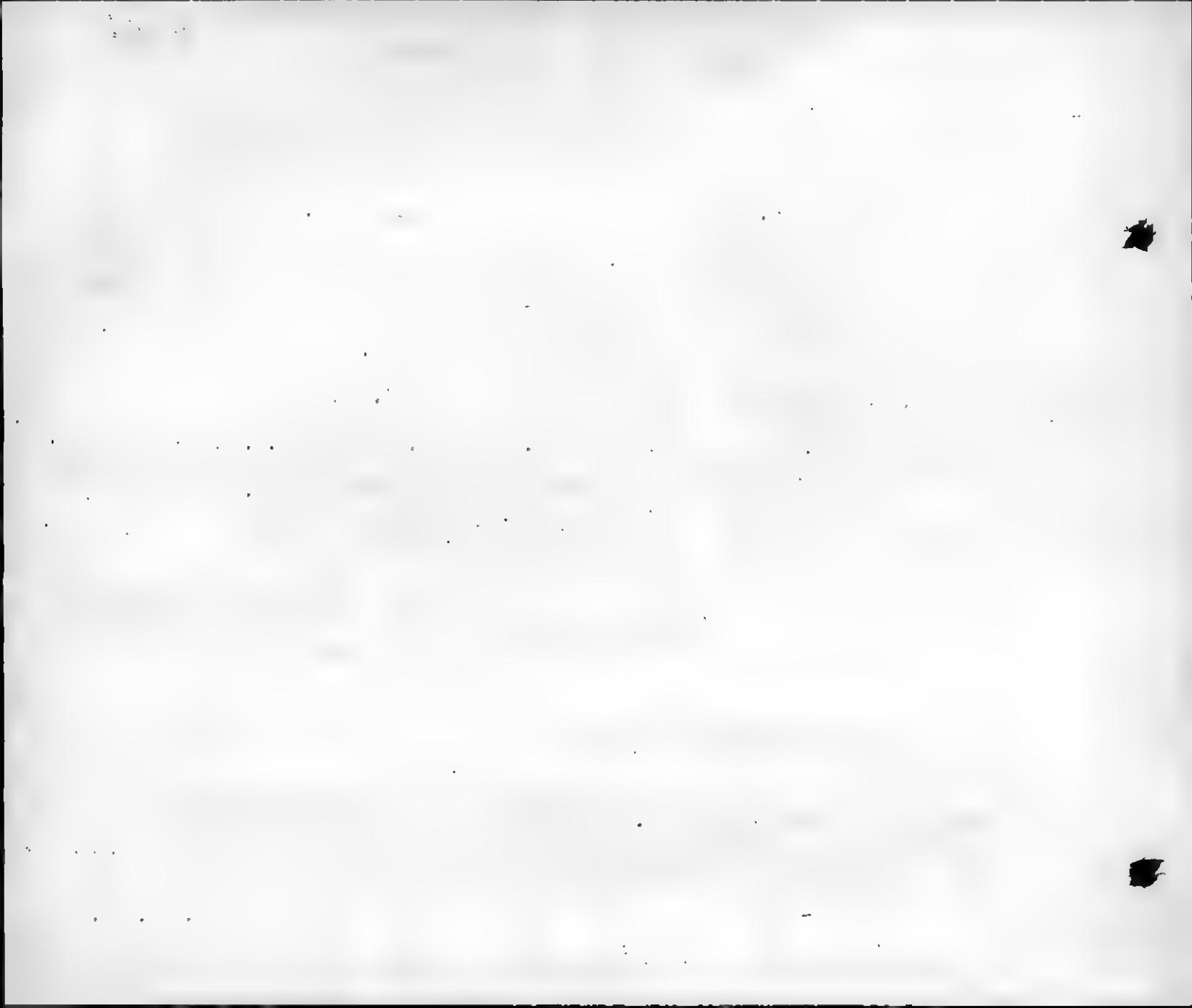
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5436

CERTIFICATE OF DEATH

05406
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh		b. COUNTY Baltimore	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ebenezer Rd.		d. STREET ADDRESS Ebenezer Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First James	Middle E.	Last Canoles
4. DATE OF DEATH	Month May	Day 12,	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9-24-1893
9. AGE (In years last birthday) 66 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.	
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dispatcher		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Canoles		14. MOTHER'S MAIDEN NAME Emma F. Brooks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 715-59-2917	
17. INFORMANT Mrs. Sophie T. Canoles		Address P.O. Box 171 White Marsh Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Diabetes M.		INTERVAL BETWEEN ONSET AND DEATH 3 mos. Hyperkinetic Cardiomas. D. I. S. 10 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/11, 1955, to 5/12, 1960, that I last saw the deceased alive on 5/12, 1960, and that death occurred at 6 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) FORK, MD.	
ACTUAL SIGNATURE CLIFFORD F. HUDSON		DATE SIGNED	
PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-14-1960	
22c. NAME OF CEMETERY OR CREMATORIAL Camp Chapel		22d. LOCATION (City, town, or county) Joppa Rd. Balto. Co. Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home 7401 Belair Rd.		ADDRESS	
		24a. REC'D BY REGISTRAR MAY 16 '60	
		24b. REGISTRAR'S SIGNATURE Cirrus S. Turner	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05407

Reg. Dist. No.

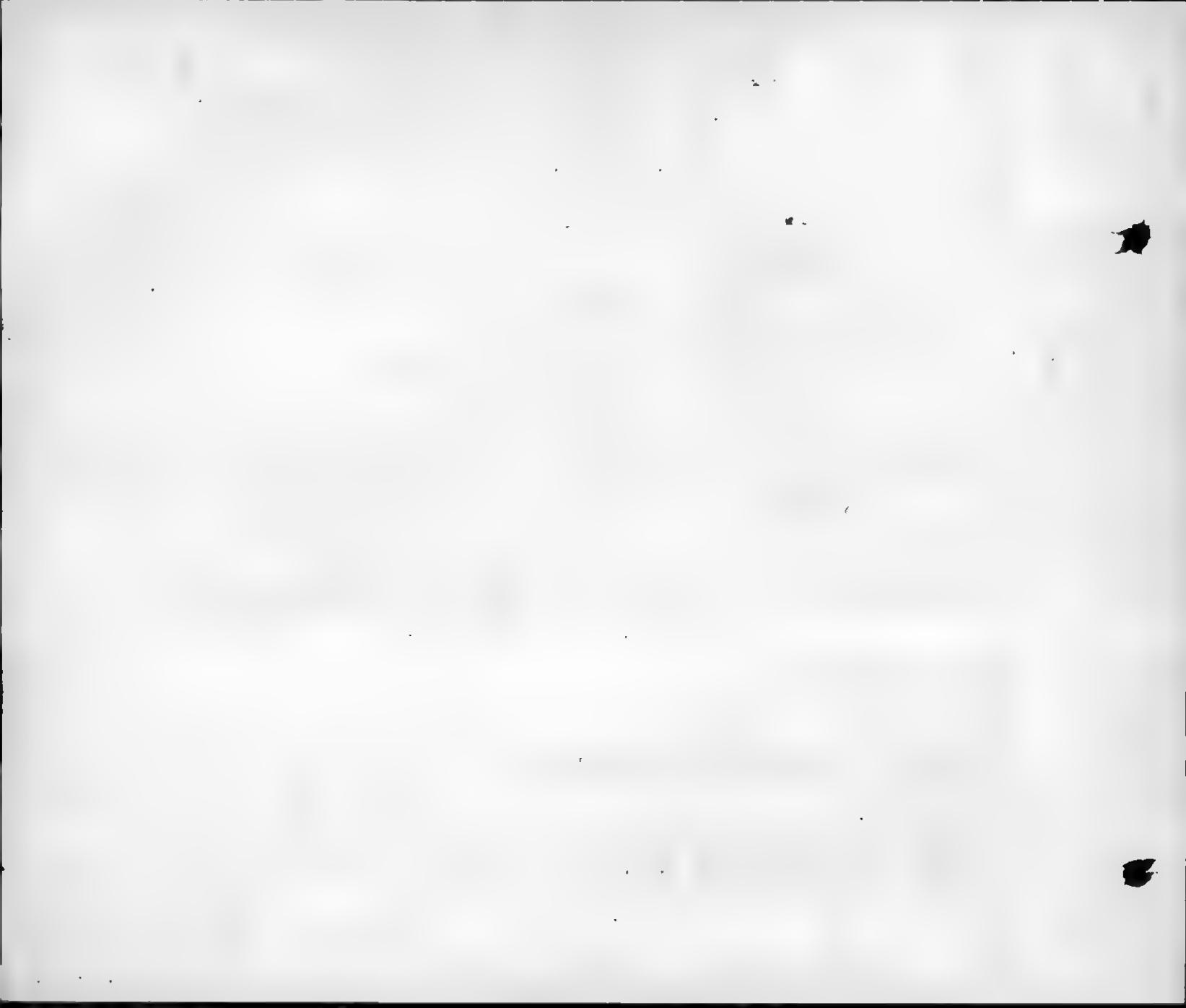
M

5437

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catoonsville		c. LENGTH OF STAY IN lb 17yr6mth16dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Louise		d. STREET ADDRESS 223 North High Street	
4. DATE OF DEATH May 13 1960		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Andrew Myers		14. MOTHER'S MAIDEN NAME Emma Henderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LIX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
Carcinoma of stomach (Linitis plastica) (c) DUE TO			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Cerebral vascular accident - Generalized arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 14, 1959, to May 13, 1960, that I last saw the deceased alive on May 13, 1960, and that death occurred at 12:45 p.m., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Bruno Radauskas, M. D.		M.D. SPRING GROVE STATE HOSPITAL 5-19-60	
PHYSICIAN'S NAME (Type)		Catoonsville 28, Maryland	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Cremation		22c. NAME OF CEMETERY OR Crematory Caledon	
22b. DATE THEREOF 5/20		22d. LOCATION (City, town, parish/county) Frederick	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Tolson		24a. REC'D BY REGISTRAR MAY 20 '60	
23b. ADDRESS 1318 Light		24b. REGISTRAR'S SIGNATURE Cuthbert S. Murch	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

5389

05408 32

Reg. Dist. No.

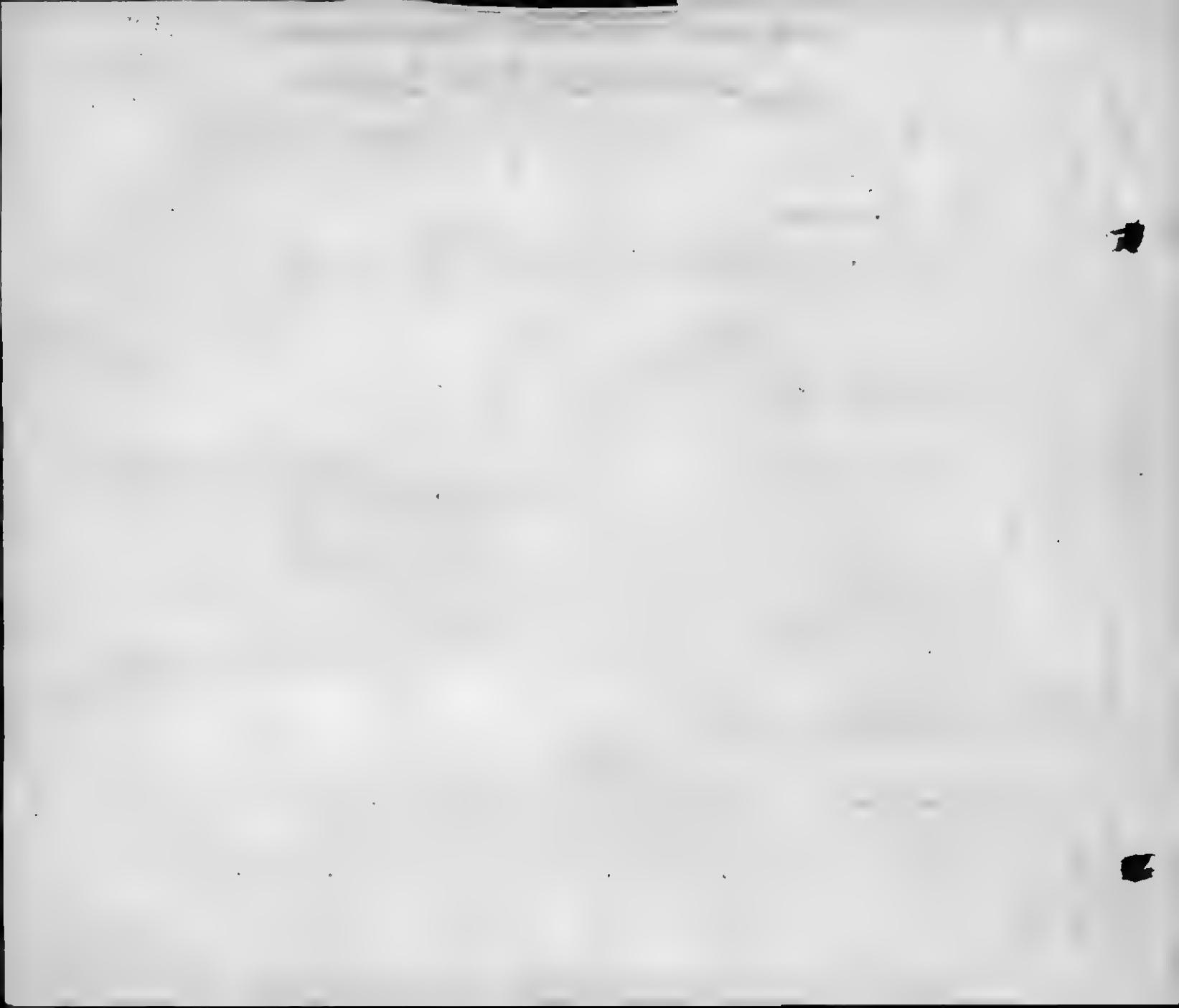
INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a funeral permit.

VS A15C 1-5 10A

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Baltimore CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN Mt. Wilson		STATE Maryland COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City 6 STREET ADDRESS 4803 Burland Avenue <small>(If rural give location)</small>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mt. Wilson State Hospital		LENGTH OF STAY (in this place) 1 yr. 3 m. 12 d.	
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
THOMAS GAETANO CASA SR		May 5 1960	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 1.3.1888.
9. AGE last birthday 72 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country) Italy
13. FATHER'S NAME Louis Casa	14. MOTHER'S MARRIED NAME Lucille Dicar	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) unknown	16. SOCIAL SECURITY NO. 215-10-1782
17. INFORMANT & ADDRESS Hospital Records Mt. Wilson State Hospital		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <input checked="" type="checkbox"/> IMMEDIATE CAUSE (A) Ruptured aortic aneurism ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. For advanced bilateral carotid jugular, pulmon. TB active			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1.23, 1959, to 5.5, 1960, that I last saw the deceased alive on 5.5, 1960, and that death occurred at 10:06 AM, from the causes and on the date stated above. SIGNATURE <i>Wm. Newcomer</i> Wm. Newcomer, M.D. Superintendent, Mt. Wilson, Maryland ADDRESS (Street, city, town, state) DATE SIGNED <i>1000 Market St.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF 5/9/60	NAME OF CEMETERY OR CREMATORIAL SACRED HEART	LOCATION (City, town, or county) BALTO MD. (State)
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <i>John S. Kline</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard G. Kline, Jr. AM 1012</i> ADDRESS <i>1000 Market St.</i>	
DATE MAY 9 '60			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

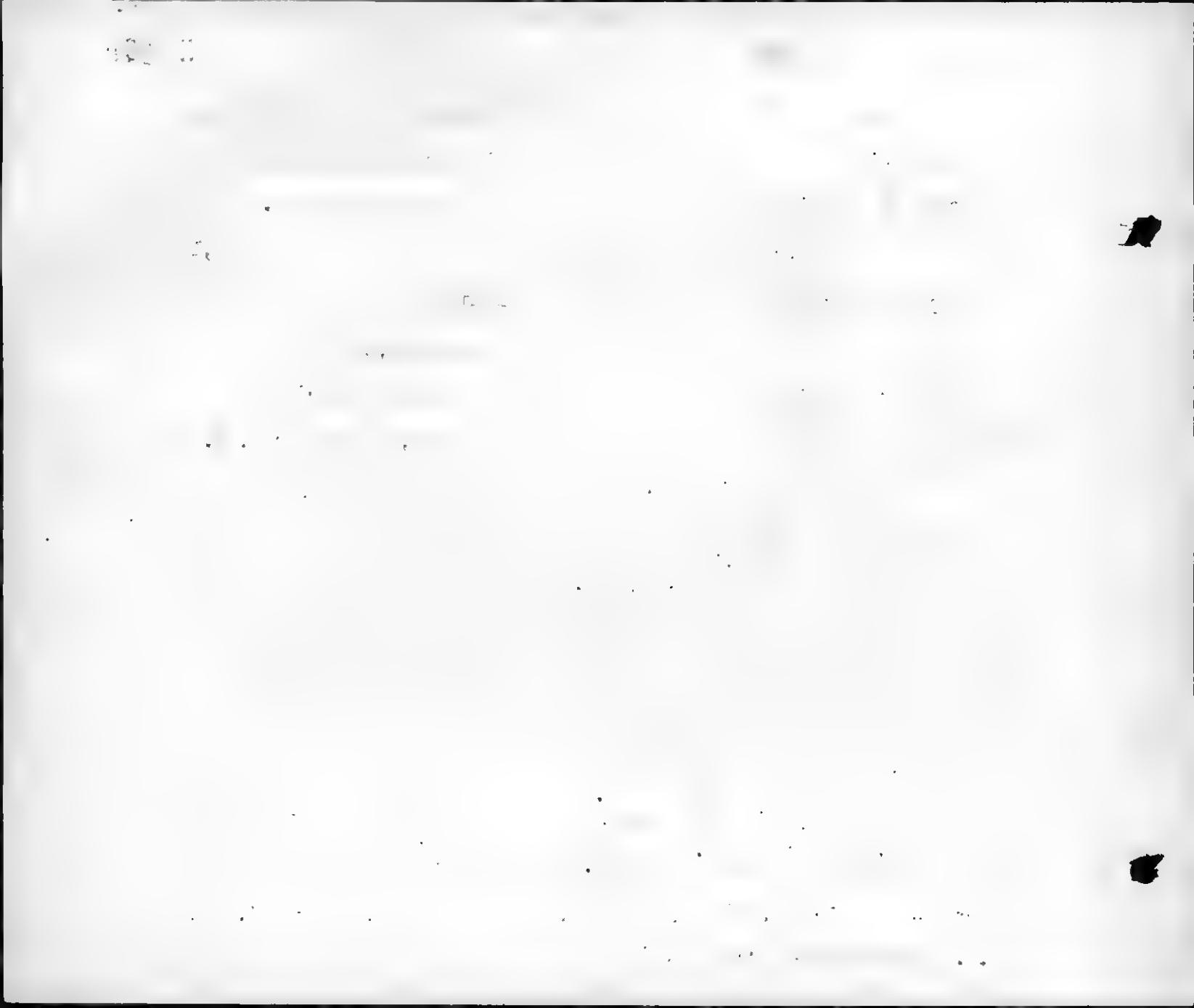
5438

CERTIFICATE OF DEATH

05409
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catoonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		d. STREET ADDRESS 22 Westchester Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MARY N CAVEY		First	Middle	Last	4. DATE OF DEATH May 30, 1960	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-1-1884		9. AGE (In years lost birthday) 75 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Hours	12. IF UNDER 24 HRS Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elchester, Md		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Patrick Durnin		14. MOTHER'S MAIDEN NAME Gelen Mc Guirk							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Emmet Cavey, Ellicott City, Md.		Address			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 174X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) DUE TO (c)		18. VASCULAR COLLAPSE Hemorrhage Carcinoma uterus				INTERVAL BETWEEN ONSET AND DEATH 15 min 30 min 1 yr.			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G. VEN IN PART I (o)						19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from May 25, 1960 to May 30, 1960 ; that I last saw the deceased alive on May 27, 1960 , and that death occurred at 615A M , from the causes and on the date stated above. ACTUAL SIGNATURE Thomas F. Herbert, M.D.				ADDRESS (Street, city or town, state) 46 Clunie Rd.		DATE SIGNED 5-30-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 2, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Good Shepherd		22d. LOCATION (City, town, or county) Ellicott City, Md		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS Ellicott City, Md	24a. REC'D BY REGISTRAR DATE JUN 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krause				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed fully, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5439

CERTIFICATE OF DEATH

05410
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BAYNESVILLE MD.		c. LENGTH OF STAY IN lb LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9011 SATYR HILL RD.		e. STREET ADDRESS 9011 SATYR HILL RD.	
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) SOPHIA	First S	Middle D	Last CLASS.
4. DATE OF DEATH APRIL 15, 1880	Month MAY	Day 18	Year 1960
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 15, 1880
9. AGE (In years last birthday) 80 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. BIRTHPLACE (State or foreign country) BALTO. MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME FREDERICK WHOLER	14. MOTHER'S MAIDEN NAME WILHELMENIA DORN.	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) No.	16. SOCIAL SECURITY NO None	INFORMANT W DEEMER CLASS. 9011 SATYR HILL RD.	17. INTERVAL BETWEEN ONSET AND DEATH 5 Hrs. at least 25 yrs.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420. Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerosis, chronic. DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Hour a. m p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10 Oct. , 1950, to 18 May , 1960, that I last saw the deceased alive on 18 May , 1960, and that death occurred at 1:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 7425 Harford Rd. DATE SIGNED 20 May 60.			
ACTUAL SIGNATURE <i>Edward L. J. Molz</i>	PHYSICIAN'S NAME (Type) EDWARD L. J. MOLZ, M.D. Baltimore (14) Ind.		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5/21/60	22c. NAME OF CEMETERY OR CREMATORIAL PARKWOOD CEM.	22d. LOCATION (City, town, or county) BALTO (State) MD.
23. FUNERAL DIRECTOR'S SIGNATURE Sassan Funeral Home 7401 Belair Rd #6	ADDRESS MD. ON MAY 24 '60	24a. REC'D BY REGISTRAR Cuthbert S. Thrane	24b. REGISTRAR'S SIGNATURE



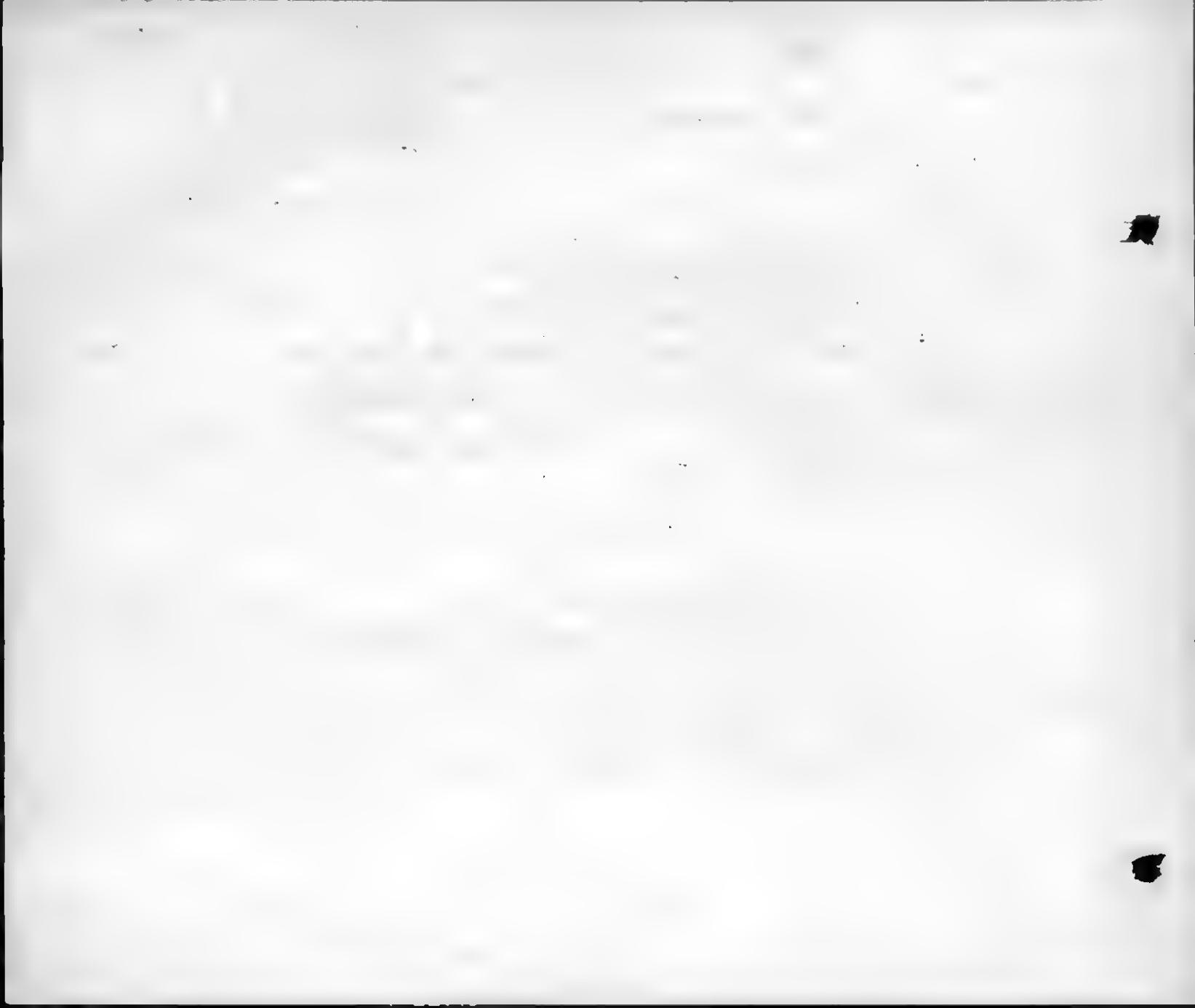
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 8, 13 & 14 Film G262 5/13/60 iwk
CERTIFICATE OF DEATH

5440 05411
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House in Pines</i>		d. STREET ADDRESS <i>7808 Mendo Drive</i>	
3. NAME OF DECEASED (Type or print) <i>Harry Cluster</i>		4. DATE OF DEATH Month <i>5</i> Day <i>8</i> Year <i>1960</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>Male</i> COLOR OR RACE <i>white</i> 6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unknown 1886 9. AGE (In years lost birthday) <i>74</i> yrs.	
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Moving Pictures</i> 11. BIRTHPLACE (State or foreign country) <i>Russia</i>	
13. FATHER'S NAME <i>Abraham Cluster</i>		14. MOTHER'S MAIDEN NAME <i>Hannah Rose Cluster - same</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>INFORMANT</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>427.3</i> DUE TO <i>Myocardial Failure</i> INTERVAL BETWEEN ONSET AND DEATH <i>6 hours</i> . Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic heart disease</i> ? DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cerebral vascular accident 4 weeks prior</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>Baltimore</i> (County) <i>Md</i> (State) <i>Maryland</i>	
21. I certify that I attended the deceased from <i>5/6</i> , 1960, to <i>5/8</i> , 1960, that I last saw the deceased alive on <i>5/8</i> , 1960, and that death occurred at <i>4 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>1047 English Rose</i> DATE SIGNED <i>5/9/60</i> ACTUAL SIGNATURE <i>Lee J. Miller</i>			
22a. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify) <i>Burial 5/10-60</i> 22b. NAME OF CEMETERY OR CREMATORIUM <i>Baltimore Hebrew</i> 22d. LOCATION (City, town, or county) <i>Baltimore Md</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis Inc 2100 Ottawa Place</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 10 1960</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

15. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, with the funeral director.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, with the funeral director.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05412

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived — If institution, Residence before admission) a. STATE	
Baltimore		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 6 Mo.	
Widderwood		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7922 ROLDREW AVE.		d. STREET ADDRESS 613 Glenwood Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
ANNIE		Marie	Connelly
4. DATE OF DEATH		Month	Day
May		2	1960
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
Jan. 12, 1895		65 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		None	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Baltimore City		United States	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John G. Mansfield		ANNIE Potts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
NO		None	
17. INFORMANT		Address	
Charlotte C. Nook		SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		6-1958-1	
153.8 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) <i>Exacerbation of colitis - perirectal</i>	
		(c) <i>June 14, 1960</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 15, 1957</i> to <i>May 2, 1960</i> that (I) (we) last saw the deceased alive on <i>Sept 7, 1960</i> , and that death occurred at <i>6:30 PM</i> , from the causes and on the date stated above.		22b. DATE SIGNED <i>5/3/60</i>	
22c. SIGNATURE <i>Frederick J. Villiger</i>		M. D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <i>one York St. Baltimore, Md.</i>	
23a. BURIAL/CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF May 5, 1960	
23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery		23d. LOCATION (City, town, or county) Baltimore Md	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Henry J. Jenkins & Sons Co.</i>		ADDRESS 4905 York Road	
25a. REC'D BY REGISTRAR DATE MAY 4 '60		25b. REGISTRAR'S SIGNATURE <i>John J. Murray</i>	
15M 9/59			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5442

CERTIFICATE OF DEATH

05413

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Jessupsville</i>		c. LENGTH OF STAY, IN 1b <i>Five</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Jessupsville</i>	
		d. STREET ADDRESS <i>Wood's Chapel Road.</i>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <i>Edward</i>	Middle <i>Scriplett</i>	Last <i>Conroy</i>	4. DATE OF DEATH <i>May 4 1960</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Nov. 17, 1866</i>	9. AGE (In years, lost birthday) <i>93 yrs.</i>
				IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
				IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Instrument maker</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Tool machinery</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13. FATHER'S NAME <i>Henry J. Conroy</i>	14. MOTHER'S MAIDEN NAME <i>Angelina Scriplett</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>?</i>	17. INFORMANT <i>Mr. W. E. Martin, Randallstown, Md.</i>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		CEREBRAL HEMORRHAGE
DUE TO DUE TO DUE TO		ARTERIOSCLEROSIS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
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20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Randallstown, Md.</i>	(County) <i></i>	(State) <i></i>
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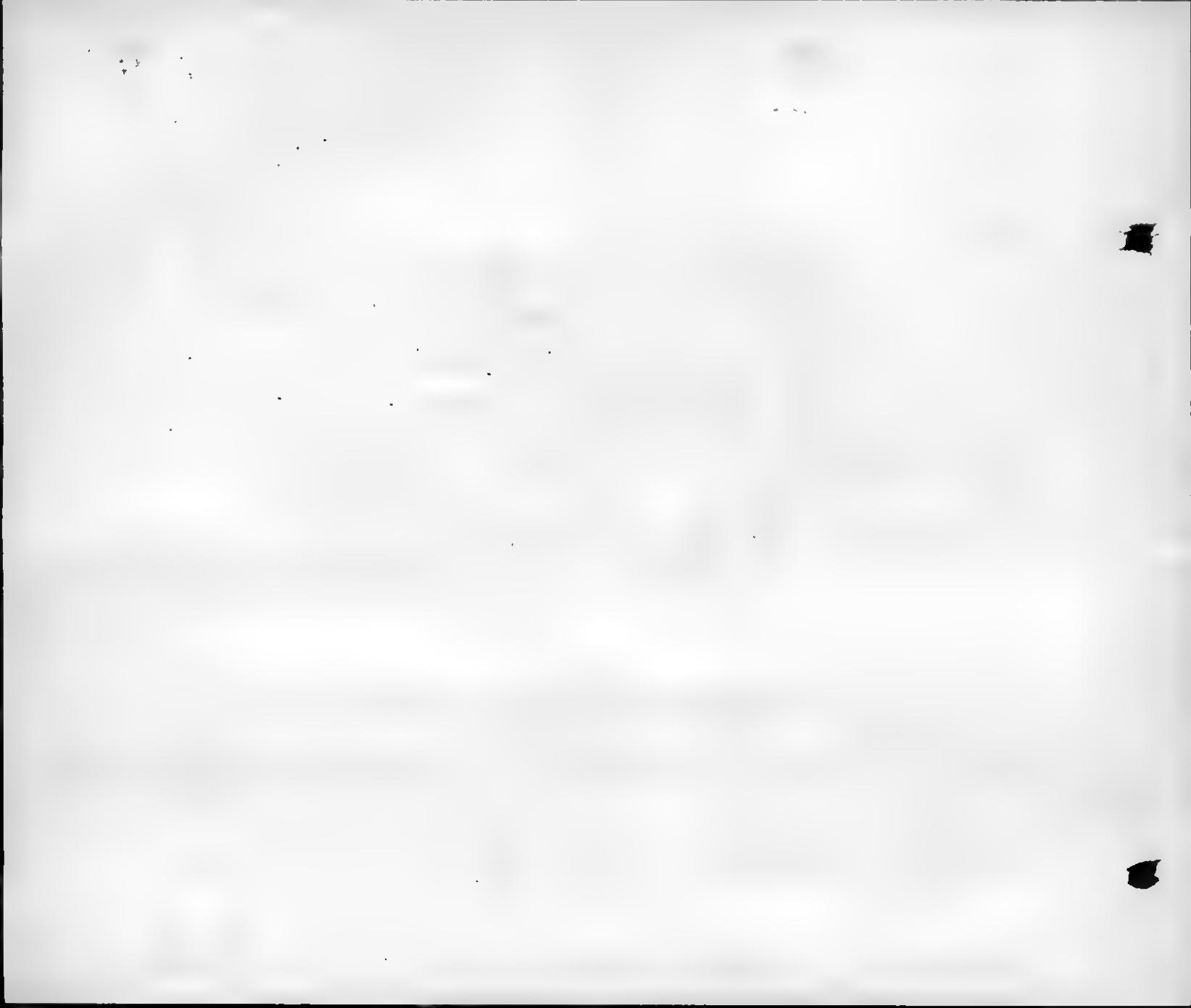
21. I certify that (I) (this hospital) attended the deceased from <i>5/4/60</i> 19 to <i>5/4/60</i> 19, that (I) (we) last saw the deceased alive on <i>5/4/60</i> 19, and that death occurred at <i>4:30 PM</i> from the causes and on the date stated above.					
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22a. SIGNATURE <i>W. E. Martin</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>5-5-60</i>
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22c. PHYSICIAN'S NAME (Type) <i>W. E. Martin</i>	22d. ADDRESS <i>Randallstown, Md.</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>5-7-60</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Brandy Ridge</i>	23d. LOCATION (City, town, or county) (State) <i>Towson, Md.</i>
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24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Haught</i>	ADDRESS <i>Wellesville, Md.</i>	25a. REC'D BY REGISTRAR DATE <i>May 10 '60</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur H. Haught</i>
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEFENDERS: This certificate should be executed within 24 hours of death. If any def. is necessary, please execute a certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5390		05414 REG. NO. 14																				
<p>1. PLACE OF DEATH a. COUNTY Baltimore</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk</p> <p>c. LENGTH OF STAY IN 1b</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 117 Honeysuckle Court</p>					<p>2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before adm ss on)</p> <p>a. STATE Maryland</p> <p>b. COUNTY</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk</p> <p>d. STREET ADDRESS 117 Honeysuckle Court</p>					<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>												
<p>3. NAME OF DECEASED (Type or print)</p> <p>First Ella Middle Louise Last Cowling</p>		<p>4. DATE OF DEATH</p> <p>Month May Day 23 Year 1960</p>		<p>5. SEX</p> <p>Female</p>			<p>6. COLOR OR RACE</p> <p>Colored</p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH</p> <p>Sept. 15, 1927</p>		<p>9. AGE (In years last birthday) 32 yrs</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) Smithfield, Virginia</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME Charlie Ensley</p>		<p>14. MOTHER'S MAIDEN NAME Mattie Bailey</p>		<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No</p>		<p>16. SOCIAL SECURITY NO 220-20-9096</p>		<p>17. INFORMANT Anthony T. Cowling - 117 Honeysuckle Court</p>		<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)</p> <p>470.1</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p>		<p>DUE TO (b)</p>		<p>Hyperkinesia</p>		<p>DUE TO (c)</p>		<p>Paroxysmal nocturnal renal disease</p>		<p>INTERVAL BETWEEN ONSET AND DEATH 5 years</p>		
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>															<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>							
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)</p>																				
<p>20c. TIME OF INJURY</p> <p>Month, Day, Year Hour a. m. 19 p. m.</p>		<p>20d. INJURY OCCURRED</p> <p>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town)</p>		<p>(County)</p>		<p>(State)</p>												
<p>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>																						
<p>ACTUAL SIGNATURE Jacell Collins</p>		<p>EXAMINER'S NAME (Type) JACELL C. COLLINS</p>		<p>M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/></p>		<p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p>		<p>DEPUTY MEDICAL EXAMINER <input type="checkbox"/></p>		<p>DATE SIGNED 5-23-60</p>												
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) Buried</p>		<p>22b. DATE THEREOF 5-27-60</p>		<p>22c. NAME OF CEMETERY OR CREMATORIAL Chuckatuck Cemetery</p>		<p>22d. LOCATION (City, town, or county) Nasamond Co., Virginia</p>		<p>(State)</p>														
<p>23. FUNERAL DIRECTOR'S SIGNATURE Roderick R. Law</p>		<p>ADDRESS 802 Madison Avenue</p>		<p>24a. REC'D BY REGISTRAR MAY 26 '60</p>		<p>24b. REGISTRAR'S SIGNATURE C. John S. Knott</p>																



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5443

CERTIFICATE OF DEATH

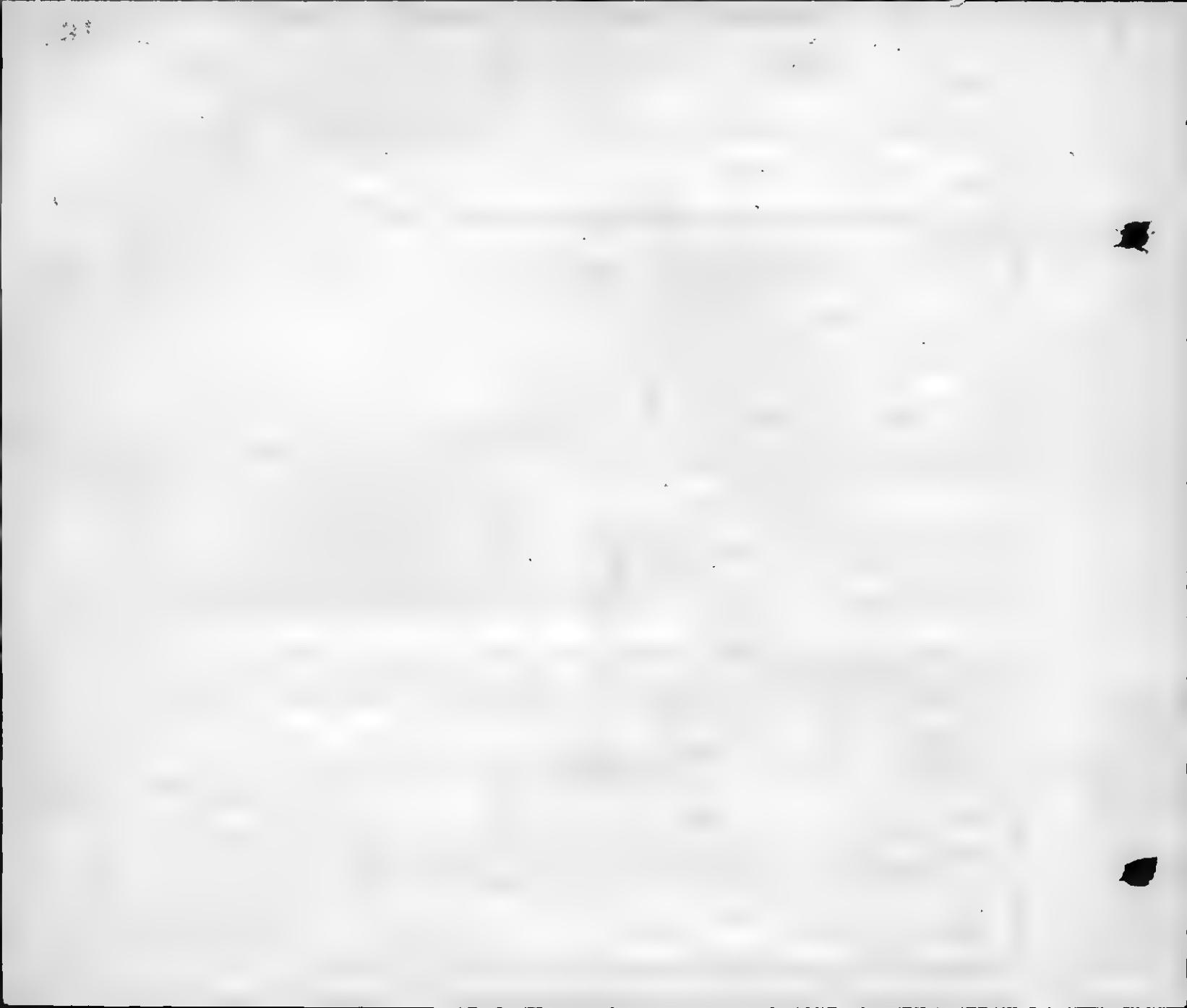
Reg. Dist. No.

05415

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WOODLAWN		c. LENGTH OF STAY IN 1b 35	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1905 ENGLEWOOD AVE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WOODLAWN	
d. STREET ADDRESS 1905 ENGLEWOOD AVE		d. STREET ADDRESS 1905 ENGLEWOOD AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ELIZABETH	Middle CHASE	Last CROSSLEY
4. DATE OF DEATH	Month MAY	Day 28	Year 1960
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 1, 1882
9. AGE (In years less birthday) 78	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
13. FATHER'S NAME THOMAS G. CHRISTIE	14. MOTHER'S MAIDEN NAME MARY E. CHASE	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 215-11-324		17. INFORMANT MRS. DAUGTER - RUTH GOODY	18. CITIZEN OF WHAT COUNTRY? U.S.A.
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) COX		Address 1905 ENGLEWOOD AVE - BALTIMORE, MD	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DIABETES MELLITUS		INTERVAL BETWEEN ONSET AND DEATH 2 days	
(b) DUE TO CONGESTIVE HEART FAILURE		10 YEARS?	
(c) MANIA		ONE YEAR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 10, 1950 , to MAY 28, 1960 , that I last saw the deceased alive on May 23, 1960 , and that death occurred at BALTIMORE, MD , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edwin L. Pierfontaine		ADDRESS (Street, city or town, state) 8104 LIBERTY RD	
PHYSICIAN'S NAME (Type) EDWIN L. PIERFONTE		DATE SIGNED 5/25/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 31, 60	
22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn		22d. LOCATION (City, town, or county) (State) BALTIMORE	
23. FUNERAL DIRECTOR'S SIGNATURE J.T. STANSBURY		ADDRESS 6411 Harford Mill	
24a. REC'D BY REGISTRAR DATE MAY 31 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5444 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05416

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
BALTIMORE MARYLAND		a. STATE Md b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) hong GREEN		c. LENGTH OF STAY IN lb 8 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MANOR Road Box 208		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) hong GREEN	
d. STREET ADDRESS MANOR Road Box 208		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) NELLIE M. CULVER		4. DATE OF DEATH Month Day Year May 14 1960	
5. SEX FEMALE		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 6 NOVEMBER 1879	
WIDOWED <input checked="" type="checkbox"/>		9. AGE (In years last birthday) 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Towson Md		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Adam C. Krout		14. MOTHER'S MAIDEN NAME Martha M. Switzer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT NONE L. MARGARETTA WILLIAMS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address Box 208 MANOR Rd	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH Sudden	
DUE TO Conditions, if any, which goe rise to immediate cause (a), stating the underlying cause last: (b)		DUE TO Generalized arteriosclerosis	
DUE TO (c)		16 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		DATE SIGNED 5/15/60	
ACTUAL SIGNATURE CHARLES F. DONALD		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 18 May 1960	
22c. NAME OF CEMETERY OR CREMATORIAL GREENMOUNT CEM		22d. LOCATION (City, town, or county) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Rolf C. Waeters		ADDRESS Pretty Stricker Sto	
24a. REC'D BY REGISTRAR MAY 17 '60		24b. REGISTRAR'S SIGNATURE Cathleen S. Thomas	
DATE			

TO DECEASED MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PHM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, or removal.



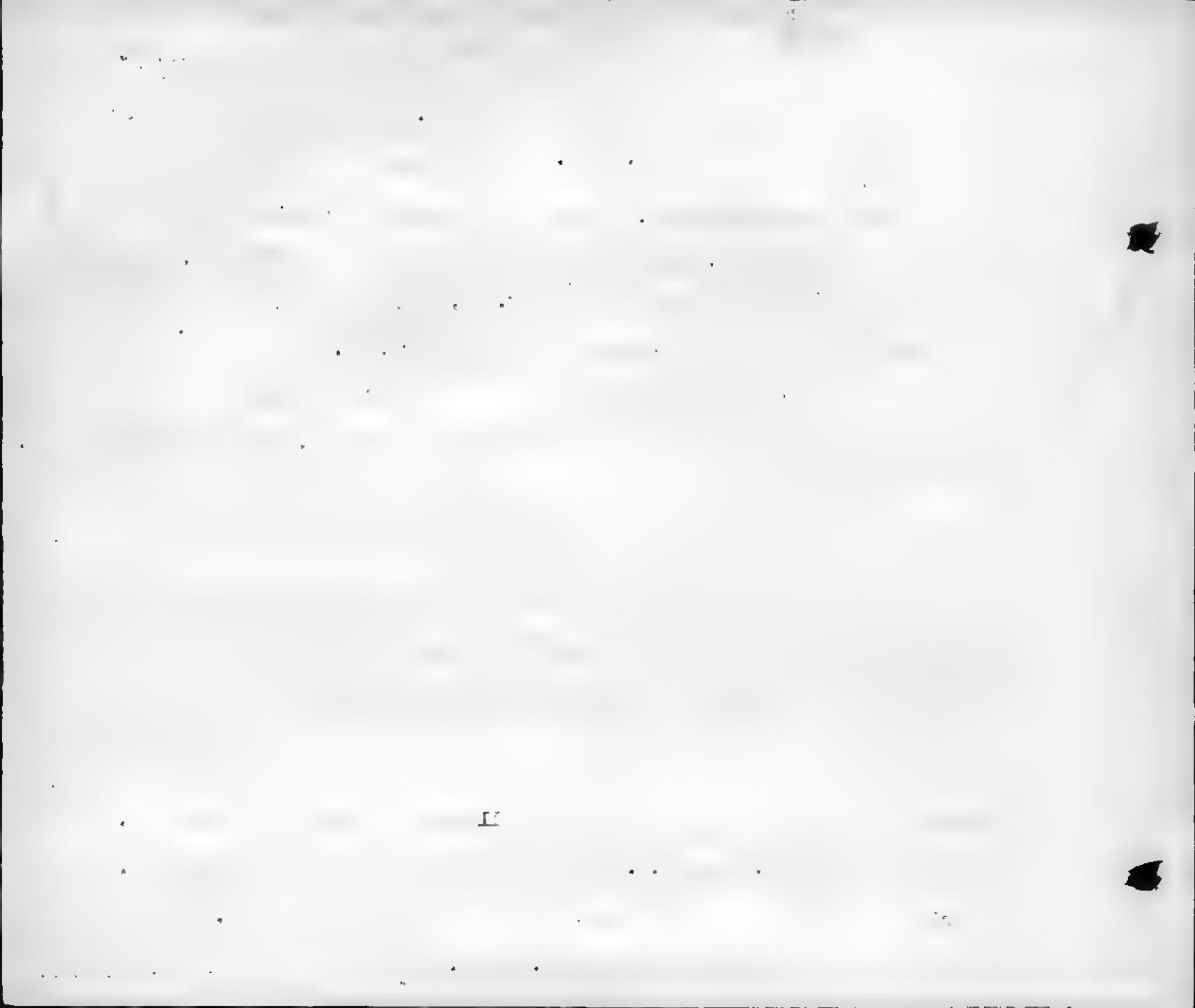
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5445 Item 2 511-525, 5-17-60 et

05417

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 1 yr. 5 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mission Helpers Convent 1001 West Joppa Road.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson	
3. NAME OF DECEASED (Type or print) Teresa C. Cunningham		First	Middle
4. DATE OF DEATH May 3rd.	Month	Day	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 16, 1875
9. AGE (in years lost birthday) 84 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Laundry	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Cunningham		14. MOTHER'S MAIDEN NAME Margaret Hughes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Convent Records, 1001 W. Joppa Road, Towson, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Failure - Chronic</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>ASCV Disease</i> (b) <i>Senile Changes</i> DUE TO (c) <i>Senile Changes</i>			
INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Senile Insufficiency</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/16</u> , 19 <u>60</u> , to <u>5/7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5/7</u> , 19 <u>60</u> , and that death occurred at <u>2:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Victor F. King</i>		ADDRESS (Street, city or town, state) 1102 East Joppa Road, Towson, Md.	
PHYSICIAN'S NAME (Type) Victor F. King, M.D.		DATE SIGNED 5/7/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/5/60	
22c. NAME OF CEMETERY OR CREMATORIUM Cathedral Cemetery		22d. LOCATION (City, town, or county) Baltimore, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. Vernon Lammom</i>		ADDRESS 4611 Park Heights Ave., Balto.	
		24a. REC'D BY REGISTRAR DATE MAY 5 '60	
		24b. REGISTRAR'S SIGNATURE <i>Charles S. Kline</i>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

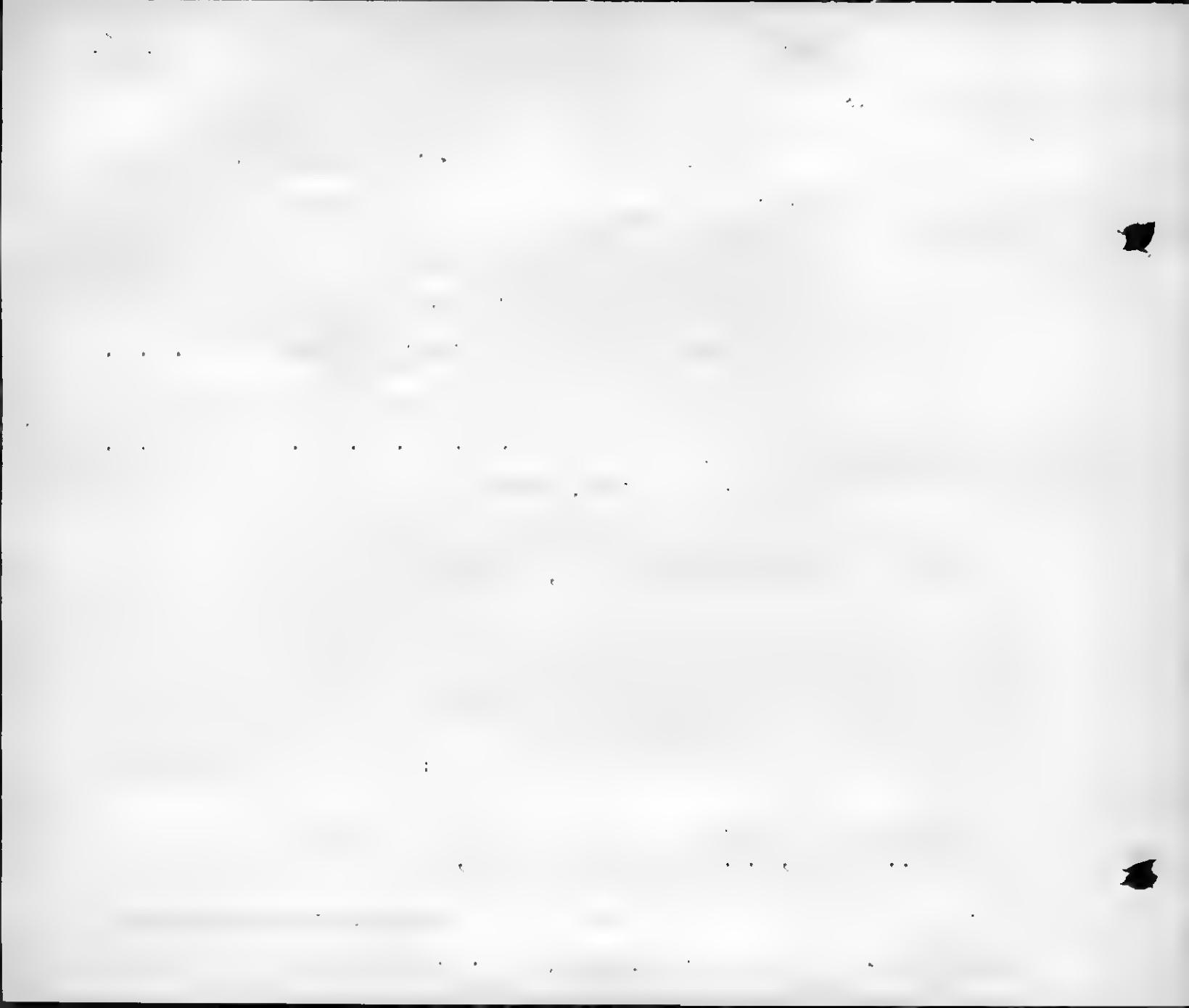
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5446

CERTIFICATE OF DEATH

05418

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 20 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1566 Ridgley Street		(30) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1566 Ridgley Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3001-4	
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle ---	Lost DELL	4. DATE OF DEATH May	Month	Day 10	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1887	9. AGE (in years lost birthday) 73 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Maker		10b. KIND OF BUSINESS OR INDUSTRY Railroad Company		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Dell				14. MOTHER'S MAIDEN NAME Mary Schmidt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO WW I		17. INFORMANT 1 st		Address Fort Howard Div. Clin. Rec., Vet. Adm. Hosp. Baltimore 18, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PYELONEPHRITIS, CHRONIC X X X X X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) UREMIC PERICARDITIS X X X X X (c) ARTERIOSCLEROSIS, GENERALIZED				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (s) (t) (this hospital) attended the deceased from April 20, 1960, to May 10, 1960, that (s) (we) last saw the deceased alive on May 10, 1960, and that death occurred 6:40 A.M. from the causes and on the date stated above.							
22a. SIGNATURE John D. Talbert				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/10/60	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.				22d. ADDRESS BALTIMORE 18, Maryland VAH, FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-13-60		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Frances G. Miller		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE C. Schwab	
Schwab Funeral Home 2101 Frederick Ave. Balto. md DATE MAY 13 '60 C. Schwab							



FOR STATE
HEALTH DEPT.

M

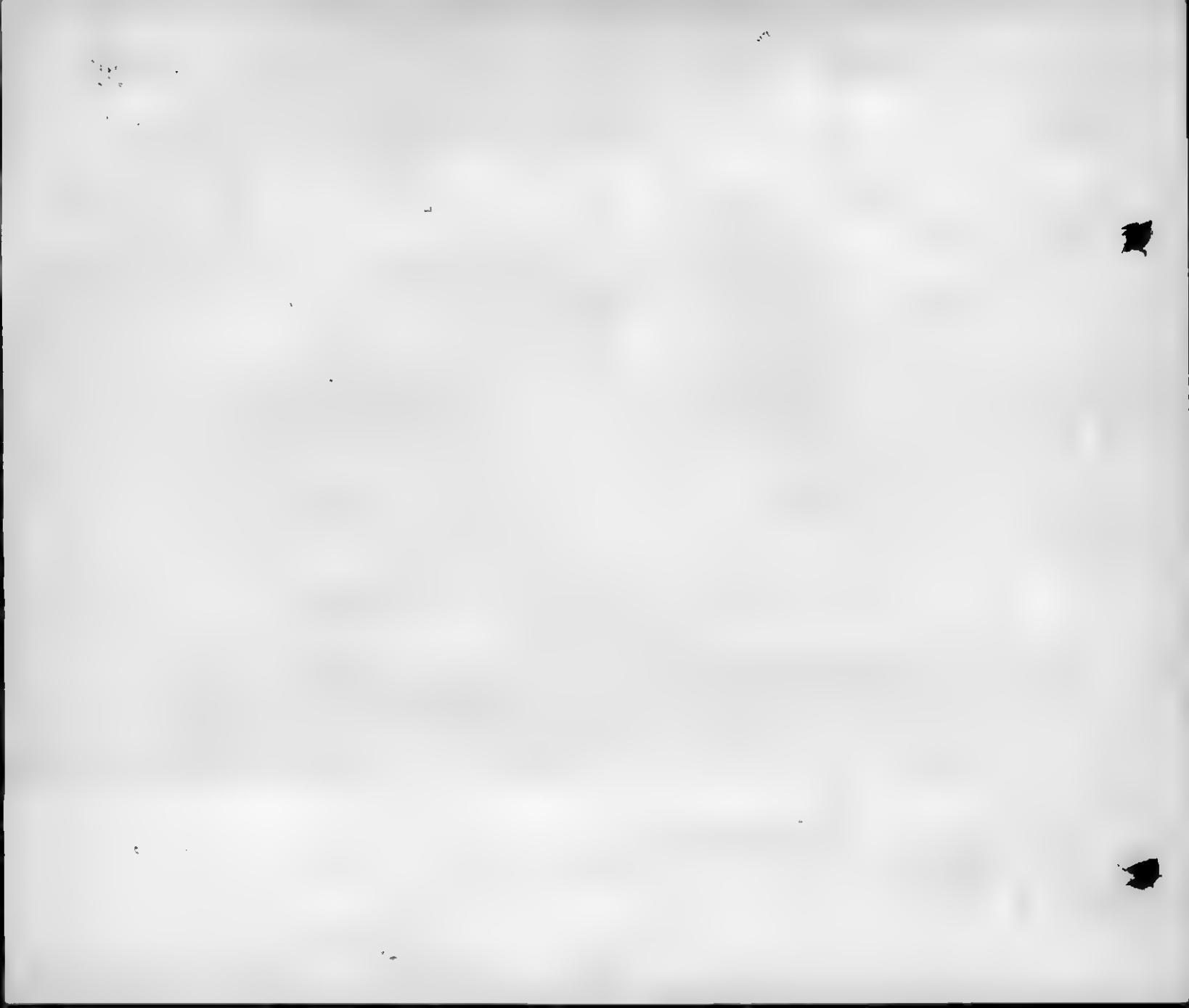
TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in my event, within 72 hours after death.

Item 19, 21 19, 21 6-1 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5447 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05419

1. PLACE OF DEATH a. COUNTY Baltimore	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	b. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	c. LENGTH OF STAY IN 1b 16	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere	d. STREET ADDRESS 2706 Lodge Farm Road
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2607 Lodge Farm Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JUANITA BARNES	First Middle Last	4. DATE OF DEATH May 28 1960	Month Dey Year
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov 21 1922
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Bucks, Pa.	9. AGE (In years last birthday) 37 yrs.	IF UNDER 1 YEAR Months Dey Hours M.n.
13. FATHER'S NAME Frank Baylor	14. MOTHER'S MAIDEN NAME Mary	12. CITIZEN OF WHAT COUNTRY? Address Theodore Baylor	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e). 20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Wm. H. Yost</i>	EXAMINER'S NAME (Type) <i>Wm. H. Yost</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED May 28, 1960
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-2-60	22c. NAME OF CEMETERY OR CREMATORIAL Mt. Calvary Cem. a. a. County Md	22d. LOCATION (City, town, or county) (State) Md
23. FUNERAL DIRECTOR Milton C. Elickson 1129 N. Carroll St	ADDRESS 1129 N. Carroll St	24a. REC'D BY REGISTRAR Arthur S. Krause	24b. REGISTRAR'S SIGNATURE Arthur S. Krause



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

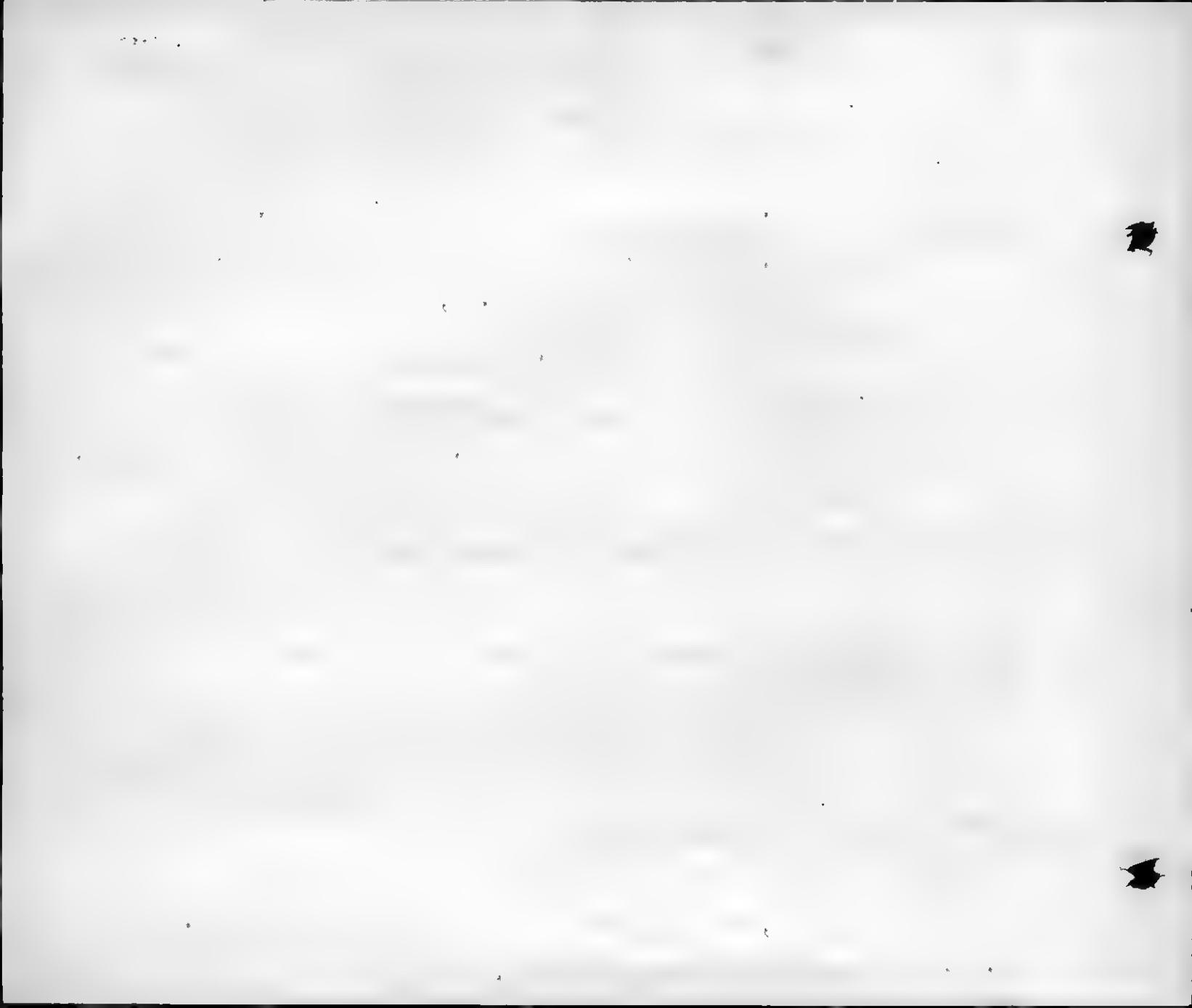
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15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5448

CERTIFICATE OF DEATH

05420
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. LENGTH OF STAY IN 1b ?		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6435 Gilmore St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		
3. NAME OF DECEASED (Type or print) Bernard S. Devilbiss		First	Middle	
4. DATE OF DEATH May 17, 1960		Last	Month Day Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1869	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Penn. Rail Rd.	11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Devilbiss		14. MOTHER'S MAIDEN NAME Deborah		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) NO		16. SOCIAL SECURITY NO. NO	17. INFORMANT Laura M. Devilbiss 6435 Gilmore St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cardio-vascular Ace</i> <i>Generalized arteriosclerosis</i>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5/15 , 19 60 , to 5/17 , 19 60 , that I last saw the deceased alive on 5/16/60 , 19 60 , and that death occurred at 8 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)
ACTUAL SIGNATURE <i>Milton Schlenoff</i>				DATE SIGNED 5/18/60
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 19, 60	22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn	22d. LOCATION (City, town, or county) (State) Woodlawn Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. T. Stansbury 6411 Windsor Mill Rd.		ADDRESS	24a. REC'D BY REGISTRAR DATE MAY 18 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thrall</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5449

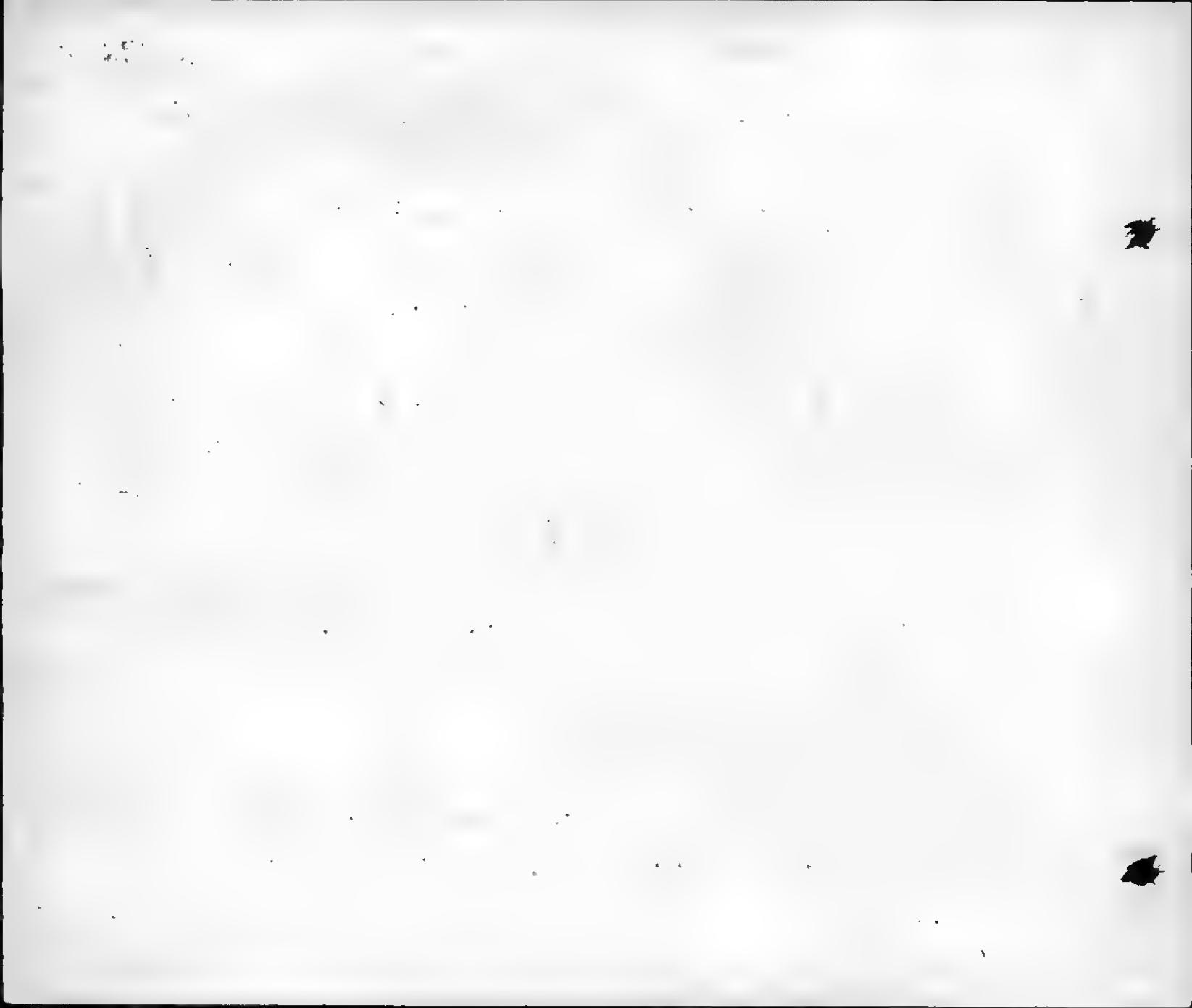
CERTIFICATE OF DEATH

Reg. No. 115-222

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived. If institution, give date before admission). a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b JUNE 22, 1960	
d. NAME OF HOSPITAL (If not in hospital, give street address) Rosewood STATE TRAINING SCHOOL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON	
f. STREET ADDRESS 115 SOUTH LANE		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Clays	Middle -	Last Dillon
4. DATE OF DEATH MAY 21 1960	Month Month	Day Day	Year Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 22, 1907
9. AGE (In years last birthday) 53 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME James Dillon		
14. MOTHER'S MAIDEN NAME Ellen Harmon		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —	
16. SOCIAL SECURITY NO. None		INFORMANT Rosewood Records	Address —
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 745X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Severe Kypho-scoliosis (c) DUE TO Severe Kypho-scoliosis			
INTERVAL BETWEEN ONSET AND DEATH 1-week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malformation of the cerebral hemispheres. - Prenatal.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Malformation of the cerebral hemispheres. - Prenatal.	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5/20/60 , 19, to 5/21/60 , 19, that I last saw the deceased alive on May 21, 1960 , and that death occurred at 155 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Starry L. Butler, M.D. Rosewood Training School			
DATE SIGNED 5/23/60			
ACTUAL SIGNATURE Harry G. Butler		PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 5/26/60	22c. NAME OF CEMETERY OR CREMATORIAL Rosewood Cem.	22d. LOCATION (City, town, or county) Owings Mills Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons	ADDRESS Reisters Town Md.	24a. REC'D BY REGISTRAR DATE MAY 27 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

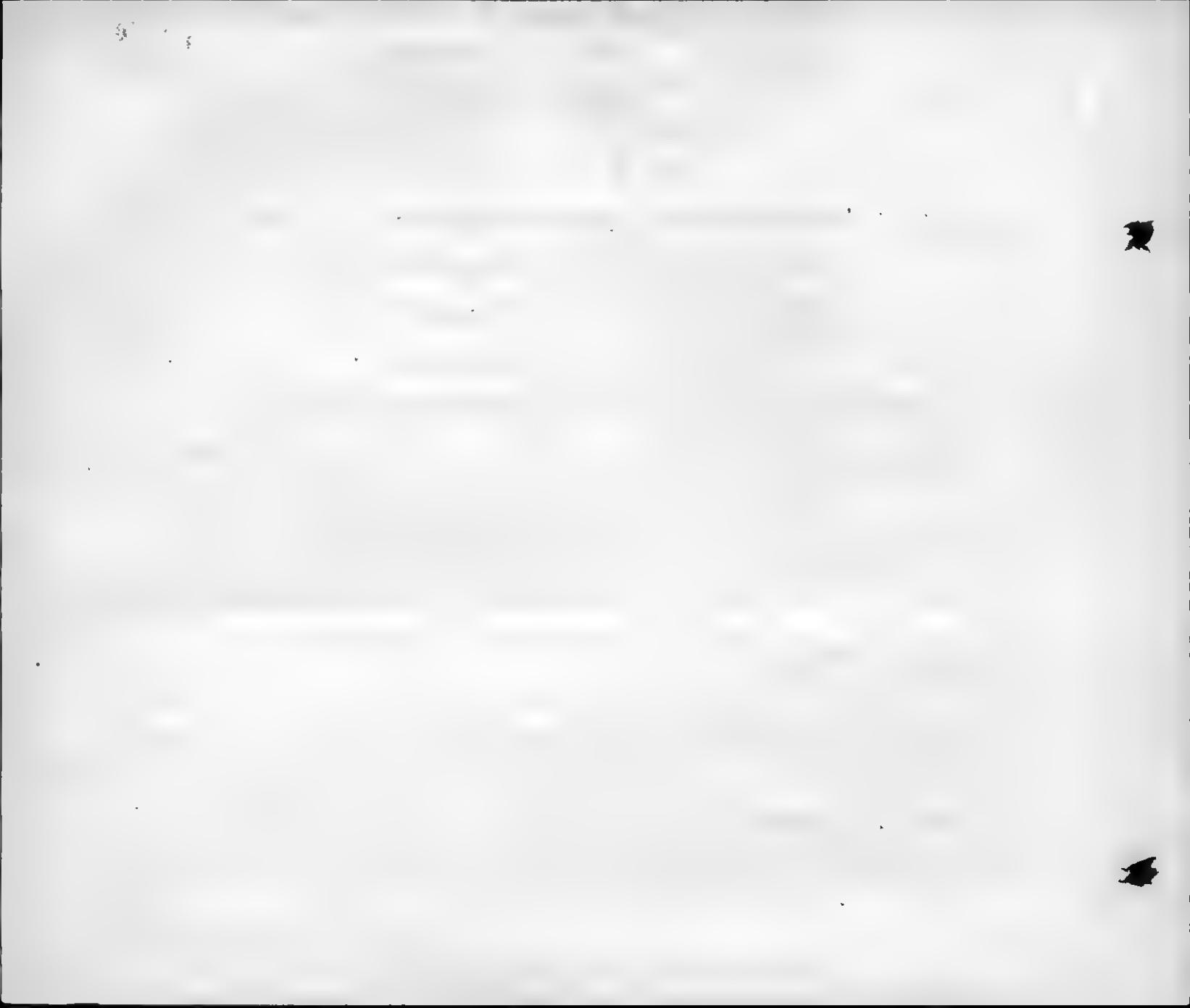
Item 2 Filmed 5-19-60 et

5450

CERTIFICATE OF DEATH

Reg (pp) 423

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. LENGTH OF STAY IN 1b 1 year	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION STELLA MARIS HOSPICE		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
f. STREET ADDRESS 808 Mt. Holly St.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
h. 3. NAME OF DECEASED (Type or print) ANNIE DIPPOLD		First	Middle
i. 4. DATE OF DEATH MAY 7 1960		Month	Day
j. 5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH FEB. 27, 1878		9. AGE (In years lost birthday) 82 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min. 11. BIRTHPLACE (State or foreign country) BALTIMORE MD.
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME MARTIN DIPPOLD	
14. MOTHER'S MAIDEN NAME MARGARET FLEISCHMAN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <input type="checkbox"/> If yes, give war or date of service Yes, served in the 1912 Regt.	
16. SOCIAL SECURITY NO. 123-45-6789		17. INFORMANT Mrs. Mary Gehret - North Shore Regt.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SIX DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1937	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 21. I certify that I attended the deceased from 1937 to 1960 that I last saw the deceased alive on May 7, 1960, and that death occurred at 11:15 P.M. from the causes and on the date stated above.		20f. (City or town) BALTIMORE (County) Md. (State)	
22. ACTUAL SIGNATURE Charles F. C'Donnell		ADDRESS (Street, city or town, state) 1501 York Rd. DATE/SIGNED 5/26/60	
23. PHYSICIAN'S NAME (Type) Charles F. C'Donnell		24a. REC'D BY REGISTRAR DATE MAY 10 '60	
24b. REGISTRAR'S SIGNATURE Charles S. Thomas			
25. BURIAL CREMATION REMOVAL (Specify) 5-11-60		22c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard & Ruck 5305 Harford		24d. LOCATION (City, town, or county) BALTIMORE Md.	
ADDRESS			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

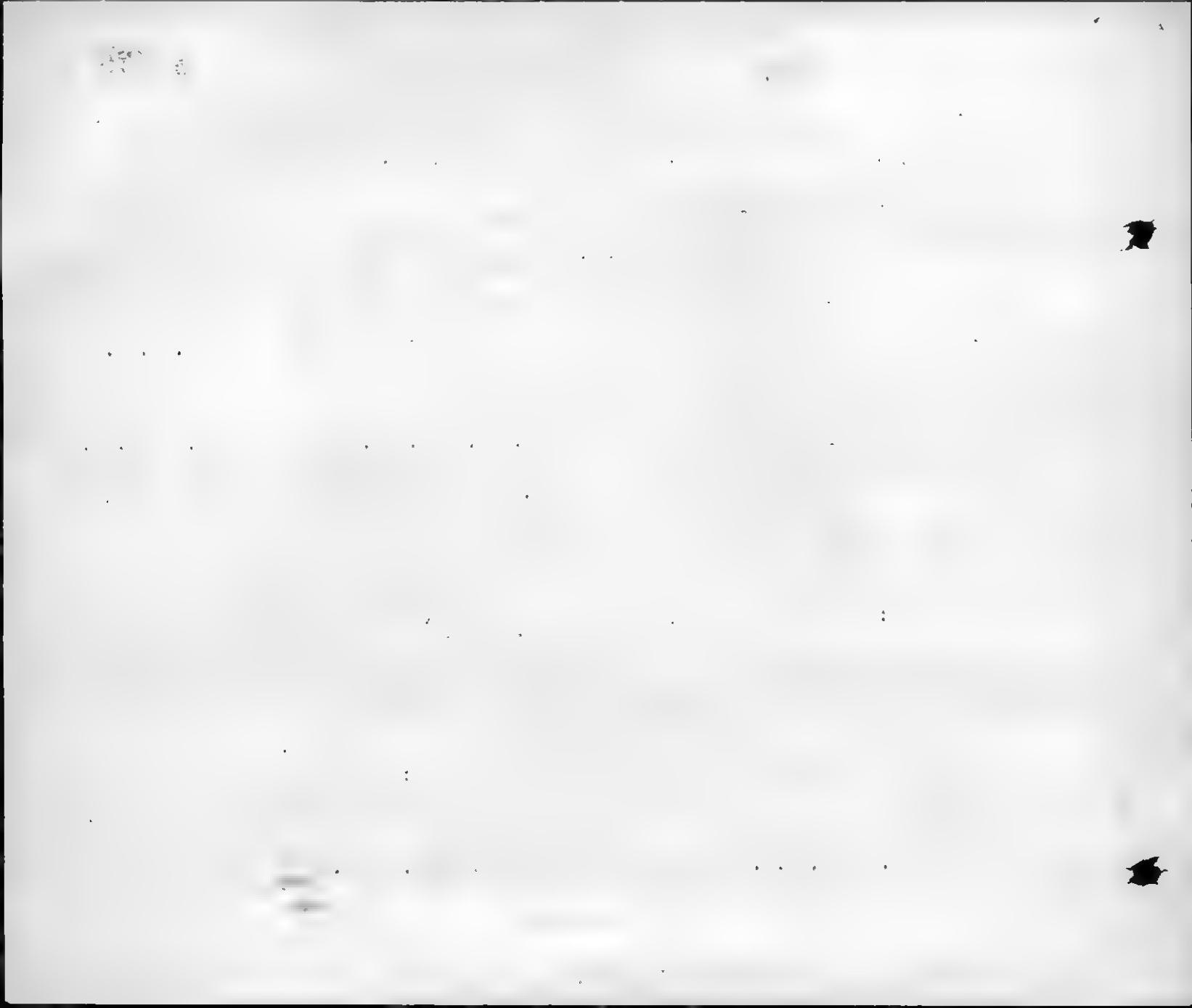
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5451

CERTIFICATE OF DEATH

05424

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Queen Ann County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 76 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville		17	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS --		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ALEXANDER	Middle ---	Last DODD	4. DATE OF DEATH	Month May	Day 6	Year 1960
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 7, 1909	9. AGE (In years last birthday) 51 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Grasonville, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alexander Dodd				14. MOTHER'S MAIDEN NAME Bessie Waters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) Yes		16. SOCIAL SECURITY NO WW II		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Balto. 18, Md. Ft. Howard		Address Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHIOGENIC CARCINOMA WITH METASTASES 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b). (c) DUE TO (b). (c) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). Operation: Aspiration of right ventricle of cranium. 3/24/60 (Revealed metastatic brain tumor) (anaplastic carcinoma of brain) (b) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Aspiration of right ventricle of cranium. 3/24/60 (anaplastic carcinoma of brain)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from February 20, 1960, to May 6, 1960, that (I) (we) last saw the deceased alive on May 6, 1960, and that death occurred at 3:45 A.M. from the causes and on the date stated above.							
22a. SIGNATURE THOMAS R. HOOD, M.D.				22b. DATE 5/6/60			
22c. PHYSICIAN'S NAME (Type) THOMAS R. HOOD, M.D.		M.D. ATTENDING PHYS <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input checked="" type="checkbox"/>	
22d. ADDRESS VAH, BALTO. 18, MD. FORT HOWARD DIVISION							
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b. DATE THEREOF MAY 9		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Chesterfield		23d. LOCATION (City, town, or county) (State) Centreville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Edgar Lane				25a. REC'D BY REGISTRAR DATE MAY 12 '60		25b. REGISTRAR'S SIGNATURE Orville L. Thomas	



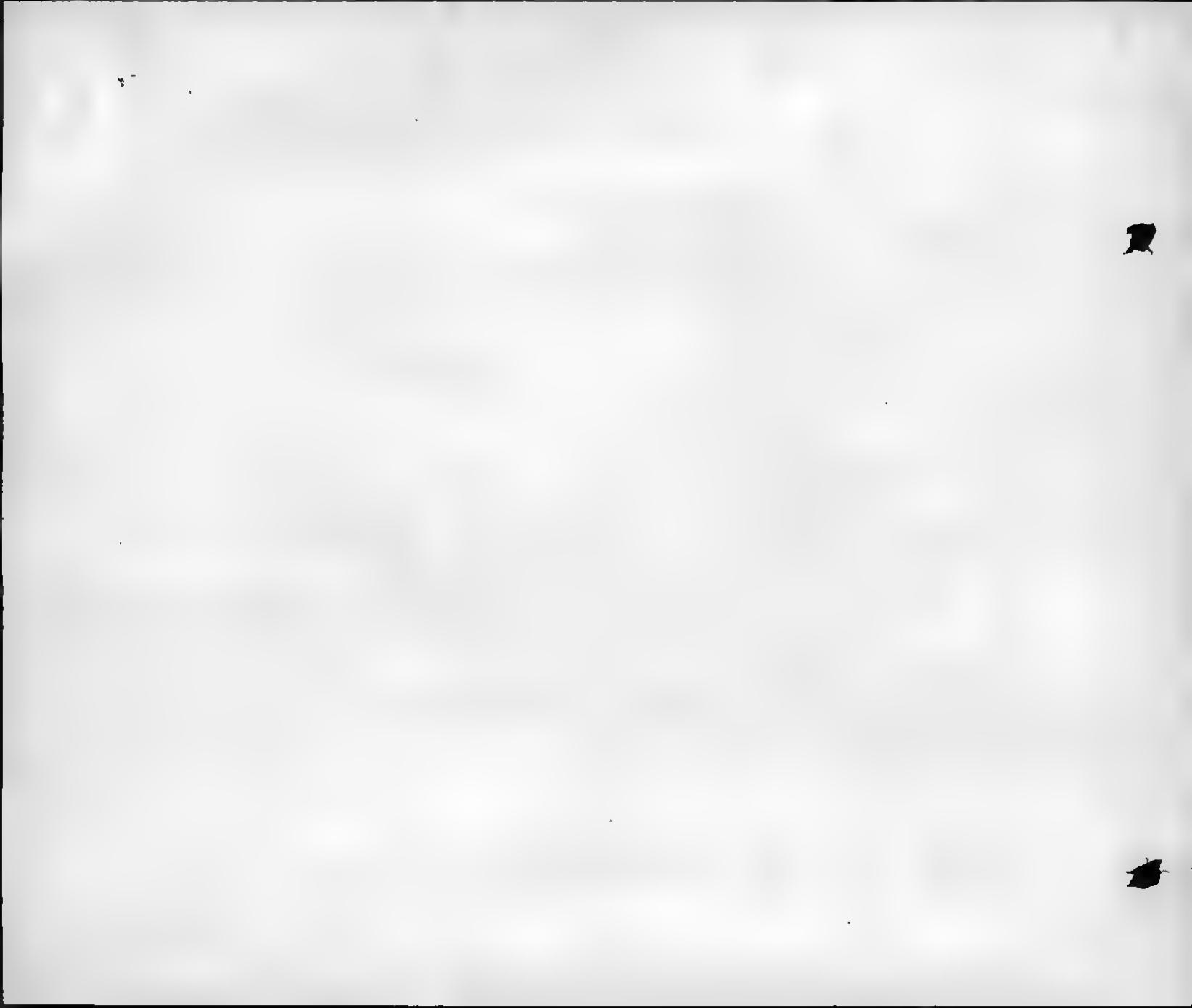
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5452

CERTIFICATE OF DEATH

05425
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) STATE <i>Maryland</i>		b. COUNTY <i>Baltimore Co.</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>3 days</i>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		f. STREET ADDRESS <i>3306 - Wiloughby</i>			
d. NAME OF HOSPITAL (if not in hospital, give street address) INSTITUTION <i>St. Luke's Hospital</i>		d. STREET ADDRESS <i>3306 - Wiloughby</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Augusta M. Deetics</i>		First	Middle	Last	4. DATE OF DEATH <i>May 29-1960</i>	Month	Day	Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 17 1885</i>		9. AGE (in years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Society</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Goods</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore MD USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Phillip Michael</i>		14. MOTHER'S MAIDEN NAME <i>Leah Deetics</i>		Address <i>William Michael MD - 1015 Poplar Grove St.</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>1015 Poplar Grove</i>		17. INFORMANT <i>William Michael MD - 1015 Poplar Grove</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1/2 hour</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>		DUE TO <i>Arterio Sclerotic type heart disease</i>		DUE TO <i>with Congestive failure - Generalized</i>		2 years.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Arterio Sclerotic type heart disease</i>		(b) <i>Arterio Sclerotic type heart disease</i>		(c) <i>with Congestive failure - Generalized</i>		several yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) <i>Paralysis of flexor muscles of left foot due to cerebral hemorrhage</i>		DUE TO <i>Arterio Sclerotic type heart disease</i>		DUE TO <i>with Congestive failure - Generalized</i>		3 years			
20a. ACCIDENT WAS UNDERLYING (e) OR CONTRIBUTING (f) CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Paralysis of flexor muscles of left foot due to cerebral hemorrhage</i>		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>December 1, 1959</i> to <i>May 29, 1960</i> , that I last saw the deceased alive on <i>May 26, 1960</i> , and that death occurred at <i>12 Noont</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>1015 Poplar Grove St Baltimore MD</i>		DATE SIGNED <i>26 May 1960</i>					
ACTUAL SIGNATURE <i>William Michael MD</i>		PHYSICIAN'S NAME (Type) <i>WILLIAM MICHAEL</i>		22d. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>6/1/60</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Lorraine Cemetery Baltimore MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H.B. Neppert - 1300 Eutaw Pl.</i>		ADDRESS <i>1300 Eutaw Pl.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 2 1960</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Moore</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5453

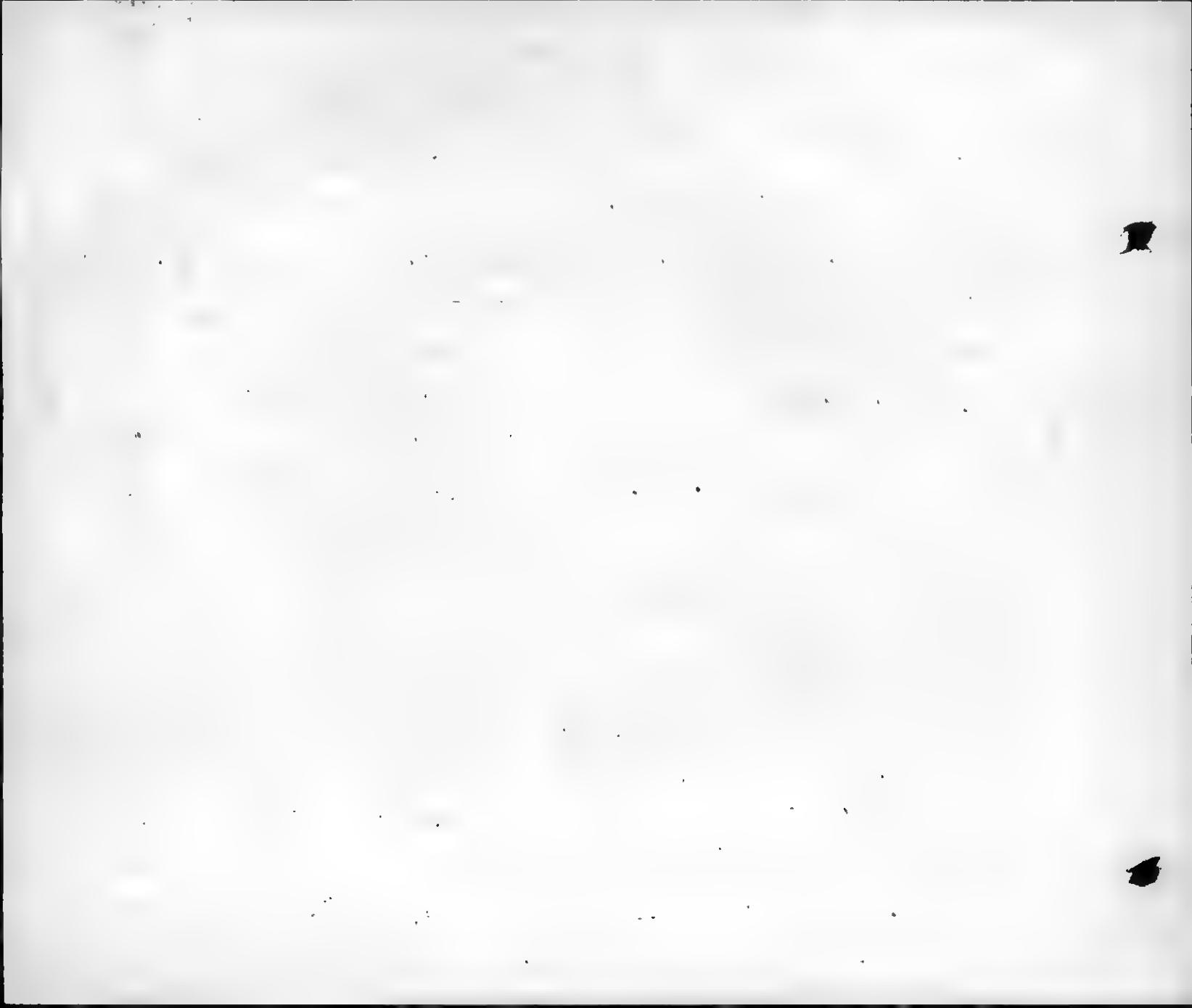
CERTIFICATE OF DEATH

05426
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesaco Park		c. LENGTH OF STAY IN 1b 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7935 Elmhurst Ave.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesaco Park	
d. STREET ADDRESS 1 7935 Elmhurst Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mr. John	Middle H.	Last Dungan, Sr.
4. DATE OF DEATH May 18, 1960	Month May	Day 18	Year 1960
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-1906
9. AGE (In years last birthday) 54 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic	11. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? USA	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME John H. Dungan	14. MOTHER'S MAIDEN NAME Margaret Thompson	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) 16. SOCIAL SECURITY NO. 212091401	17. INFORMANT Evelyn L. Dungan
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO		19. INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5/17 , 19 60 , to 5-18 , 19 60 , that I last saw the deceased alive on 5/17 , 19 60 , and that death occurred at 6 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE M. Baumgardner	ADDRESS (Street, city or town, state) Baltimore, Md.	DATE SIGNED 5/18/60	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/21/60	22c. NAME OF CEMETERY OR CREMATORIAL Baltimore Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road.	ADDRESS	24a. REC'D BY REGISTRAR DATE MAY 24 '60	24b. REGISTRAR'S SIGNATURE Callie S. Kuhn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
5391 CERTIFICATE OF DEATH						05427 Reg. Dist. No.					
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)			c. LENGTH OF STAY IN 1b 14 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2618 Yorkway						d. STREET ADDRESS 2618 Yorkway					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) SARAH		First	Middle	Last	4. DATE OF DEATH May 17th, 1960		Month	Day	Year		
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1880	9. AGE (In years lost birthday) 80 yrs.		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Scotland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles A. James						14. MOTHER'S MAIDEN NAME Sarah Hirst					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none			17. INFORMANT Mrs. Mary Amann			Address same as #2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.											
(b) Lobar pneumonia DUE TO Arterio-sclerotic heart disease with arteries Angina pectoris 34 years											
(c) arterio-sclerotic Cirrhosis of the liver DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 2-16 , 19 60 , to 5-17 , 19 60 , that I last saw the deceased alive on 5-17 , 19 60 , and that death occurred at 1:35 A.M. from the causes and on the date stated above.									ADDRESS (Street, city or town, state) M.D. 7001 Mornington Road		
ACTUAL SIGNATURE Eugene F. Nevy									DATE SIGNED 5/17/60		
PHYSICIAN'S NAME (Type) Eugene F. Nevy, M.D.						Baltimore 22, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 5/20/60			22c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn Cemetery			22d. LOCATION (City, town, or county) Baltimore Co., Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley						ADDRESS Dundalk 22					
						24a. REC'D BY REGISTRAR DATE MAY 20 '60			24b. REGISTRAR'S SIGNATURE John S. Koenig		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5404

CERTIFICATE OF DEATH

05429
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CARNEY		c. LENGTH OF STAY IN 1b 14 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9626 ALDA Drive		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CARNEY	
3. NAME OF DECEASED (Type or print) JONIUS H. DUVAL		d. STREET ADDRESS 9626 ALDA Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. SEX M	4. DATE OF DEATH MAY 19 1960	5. COLOR OR RACE W	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
7. 7. DATE OF BIRTH 69 yrs	8. AGE (In years at birthday) 69 yrs	9. IF UNDER 1 YEAR Months 0	10. IF UNDER 24 HRS Days 0
11. BIRTHPLACE (State or foreign country) New York	12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME Robert Duval	14. MOTHER'S MAIDEN NAME SALLY HART		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 420-1	16. SOCIAL SECURITY NO. 015-03-2506	17. INFORMANT JENNIE DUVAL	Address Same
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH Present	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Arteriosclerotic cardiovascular disease 20 yrs			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic hypertension			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 19, 1960 to May 19, 1960 , that I last saw the deceased alive on May 18, 1960 , and that death occurred at 10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8100 University Avenue, Bronx, N.Y. DATE SIGNED 2/24/60			
ACTUAL SIGNATURE Robert J. Duval			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF May 23, 1960	22c. NAME OF CEMETERY OR CREMATORIUM ST. ANN'S	22d. LOCATION (City, town, or county) (State) MOORSCROFT, N.Y.
23. FUNERAL DIRECTOR'S SIGNATURE Chas. F. Evans & Son		23. ADDRESS 8802 Hartford Rd	24a. REC'D BY REGISTRAR MAY 23 '60
		24b. REGISTRAR'S SIGNATURE Arthur S. Knapp	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be signed by the hospital or attending physician.

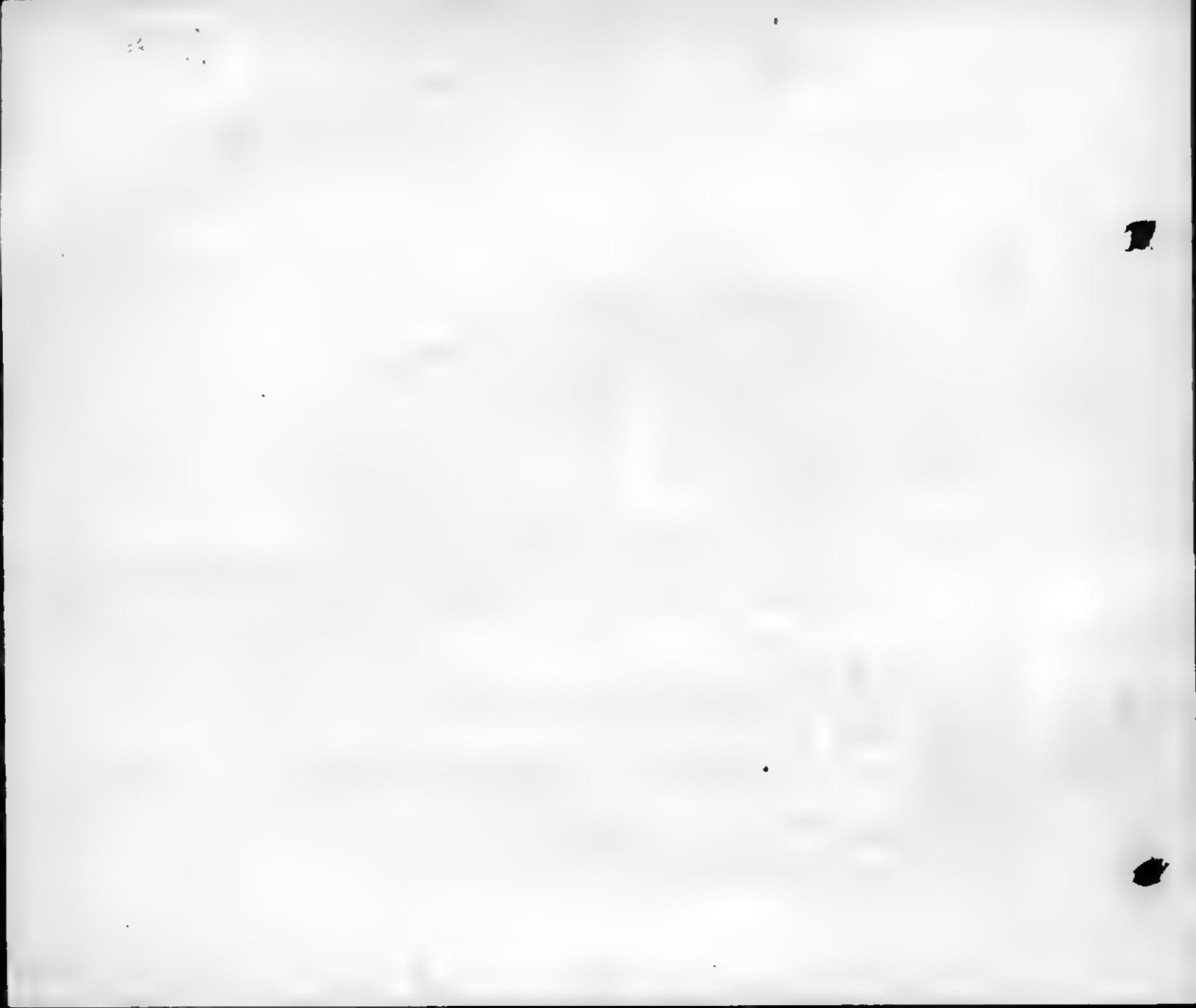
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5454 05428

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Halethorpe</i>		b. COUNTY <i>Baltimore</i>	
c. LENGTH OF STAY IN 1b <i>8 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Halethorpe</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1725 Winans Ave.</i>		d. STREET ADDRESS <i>1725 Winans Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Elmer</i>	Middle <i>U.</i>	Last <i>Duvall</i>
4. DATE OF DEATH	Month <i>May</i>	Day <i>5</i>	Year <i>1960</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 16, 1887</i>
9. AGE (in years last birthday) 72 yrs	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	11. IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stove Worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>National Enam.</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Duvall</i>		14. MOTHER'S MAIDEN NAME <i>Ella Kline</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>216-03-9374</i>	
17. INFORMANT <i>Lillie C. Duvall</i>		Address <i>1725 Winans Ave</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO <i>Congestive Heart Failure</i>	
		DUE TO (b) <i>Acute Myocardial Infarction</i>	
		DUE TO (c) <i>Arterio Sclerotic Cardio Muscular Disease</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 1957</i> to <i>5/6 1960</i> , that (I) (we) last saw the deceased alive on <i>5/6 1960</i> , and that death occurred at <i>2:27 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>James N. Frederick M.D.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>James N. Frederick M.D.</i>		22d. ADDRESS <i>1305 Francis Ave Bldg. 27 Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/9/60</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Loudon Park</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Ambrose Inc 1321 Sulphur Spring Rd</i>		ADDRESS	
		25a. REC'D BY REGISTRAR DATE <i>MAY 9 '60</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles S. Thomas</i>	



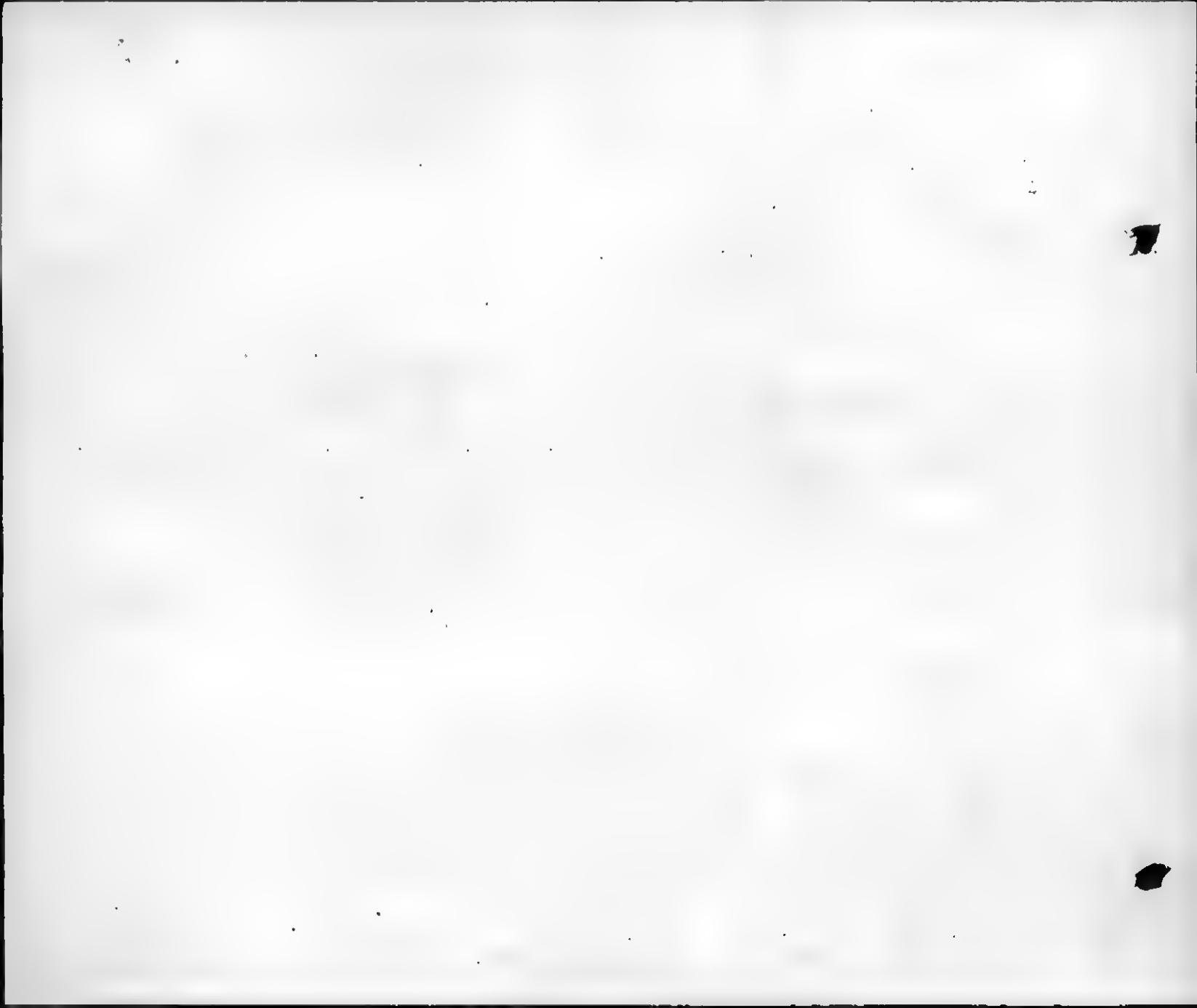
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5455

CERTIFICATE OF DEATH

05430
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		b. COUNTY Baltimore	
c. LENGTH OF STAY IN TB 5508 Windsor Mill Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5508 Windsor Mill Road		d. STREET ADDRESS 5508 Windsor Mill Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MATILDA	First E.	Middle DUVALL	4. DATE OF DEATH May 16 1960
5. SEX Fe Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1880
9. AGE (In years last birthday) 79 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Anne Arundel Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Thomas Arnold		
14. MOTHER'S MAIDEN NAME Eugenia Meubern		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		INFORMANT J. Brooke Duvall, Jr., 300 Gateswood Rd. - 4	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>570.5</i> - Arterio - Sclerotic Heart Disease DUE TO (c) <i>570.5</i> - Arterio - Sclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASIDE CONDITION GIVEN IN PART I (a) - Proximate of Vagina & Rectum -			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Baltimore	(County) Baltimore	(State) Maryland	
21. I certify that I attended the deceased from <i>March - 61959</i> to <i>May 16 - 1960</i> , that I last saw the deceased alive on <i>May 15 - 1960</i> , and that death occurred at <i>5 A. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Earl L. Chambers</i>		ADDRESS (Street, city or town, state) <i>4108 Liberty Hts. - Baltimore - 51620</i>	
PHYSICIAN'S NAME (Type) Earl L. Chambers		DATE SIGNED <i>May 17 1960</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/18/1960	22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery	22d. LOCATION (City, town, or county) Woodlawn
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ellsworth Armacost</i>		ADDRESS <i>4600 Liberty Ave.</i>	24a. REC'D BY REGISTRAR DATE <i>May 17 '60</i>
			24b. REGISTRAR'S SIGNATURE <i>Walter S. Kress</i>



1
FOR STATE
HEALTH DEPT.

4
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File Pages 1 and 2 with the State Board of Health. X
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA3. Page 5 may be retained for your files.

VS. AISME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5458 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05431

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Kingsville

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Box 416, Rt. 1, Sunshine Avenue

3. NAME OF
DECEASED
(Type or print)

CLARENCE

P.

4. SEX

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Labor

10b. KIND OF BUSINESS OR INDUSTRY

4. DATE
OF
DEATH

Month
May
1, 1960

8. DATE OF BIRTH

12-12-95

9. AGE (In years
last birthday)
64 yrs.

IF UNDER 1 YEAR
Months
Days
Hours
IF UNDER 24 HRS
Hours
1 Min.

13. FATHER'S NAME

George Ebberts

14. MOTHER'S MAIDEN NAME

Clara Kaupp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or details of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

Frederick E. Hilmer. 721 N. Woodington Rd.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work Not While at work
p.m. 19 at work

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

5/2/60

ACTUAL
SIGNATURE
Russell S. Fisher
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION
REMOVAL (Specify)
Burial

22b. DATE THEREOF
5-4-60

22c. NAME OF CEMETERY OR CREMATORIAL
Loudon Park Cemetery.

22d. LOCATION (City, town, or county)
Baltimore, Md.

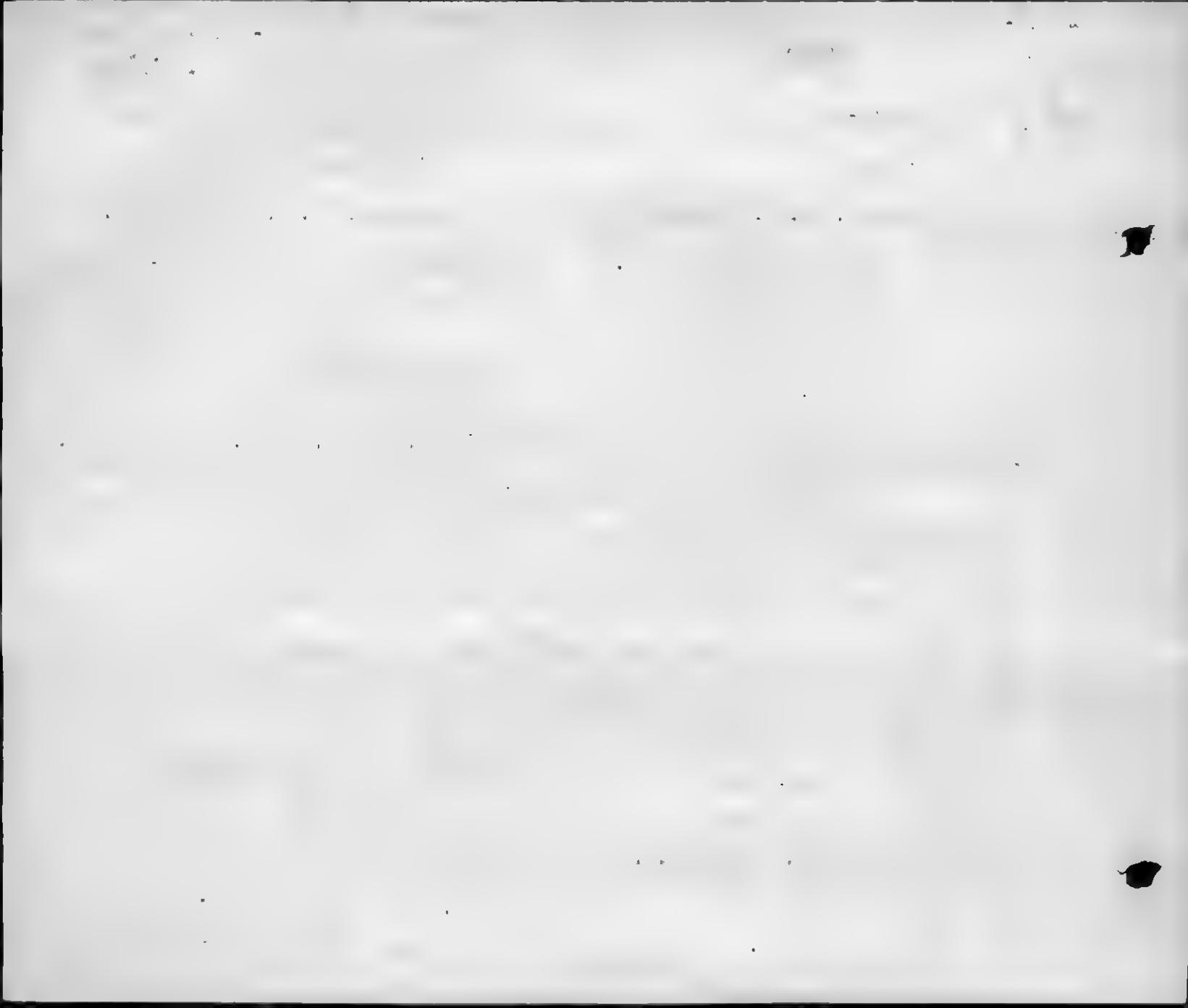
(State)

23. FUNERAL DIRECTOR

ADDRESS
Wm. Cook Blight Inc. 6009 Harford Rd. (14)

24a. REC'D BY REGISTRAR
DATE
MAY 5 '60

24b. REGISTRAR'S SIGNATURE
Arthur S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05432

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 53			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 222 Riverview Ave.		d. STREET ADDRESS 222 Riverview Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Julia	Middle Eberius	4. DATE OF DEATH May 7, 1960		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1878		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ? Seipp		14. MOTHER'S MAIDEN NAME Dont Know			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.	17. INFORMANT Royal Eberius 220 Riverview Ave.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) May 5, 1960	20f. (City or town) Colgate, Md.	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from May 5, 1960, to May 7, 1960, that (I) (we) last saw the deceased alive on May 5, 1960, and that death occurred at 12 P.M. from the causes and on the date stated above.					
22a. SIGNATURE M. B. Davis M.D.		M.D.	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 5/11/60	
22c. PHYSICIAN'S NAME (Type) M. B. Davis M.D.		22d. ADDRESS 6800 Mornin'ton Rd. Dundalk, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/11/60	23c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn	23d. LOCATION (City, town, or county) Colgate, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.		ADDRESS Ullrich Funeral Home 4210 Belair Road.		25a. REC'D BY REGISTRAR May 13 '60	25b. REGISTRAR'S SIGNATURE John S. Thrane



1

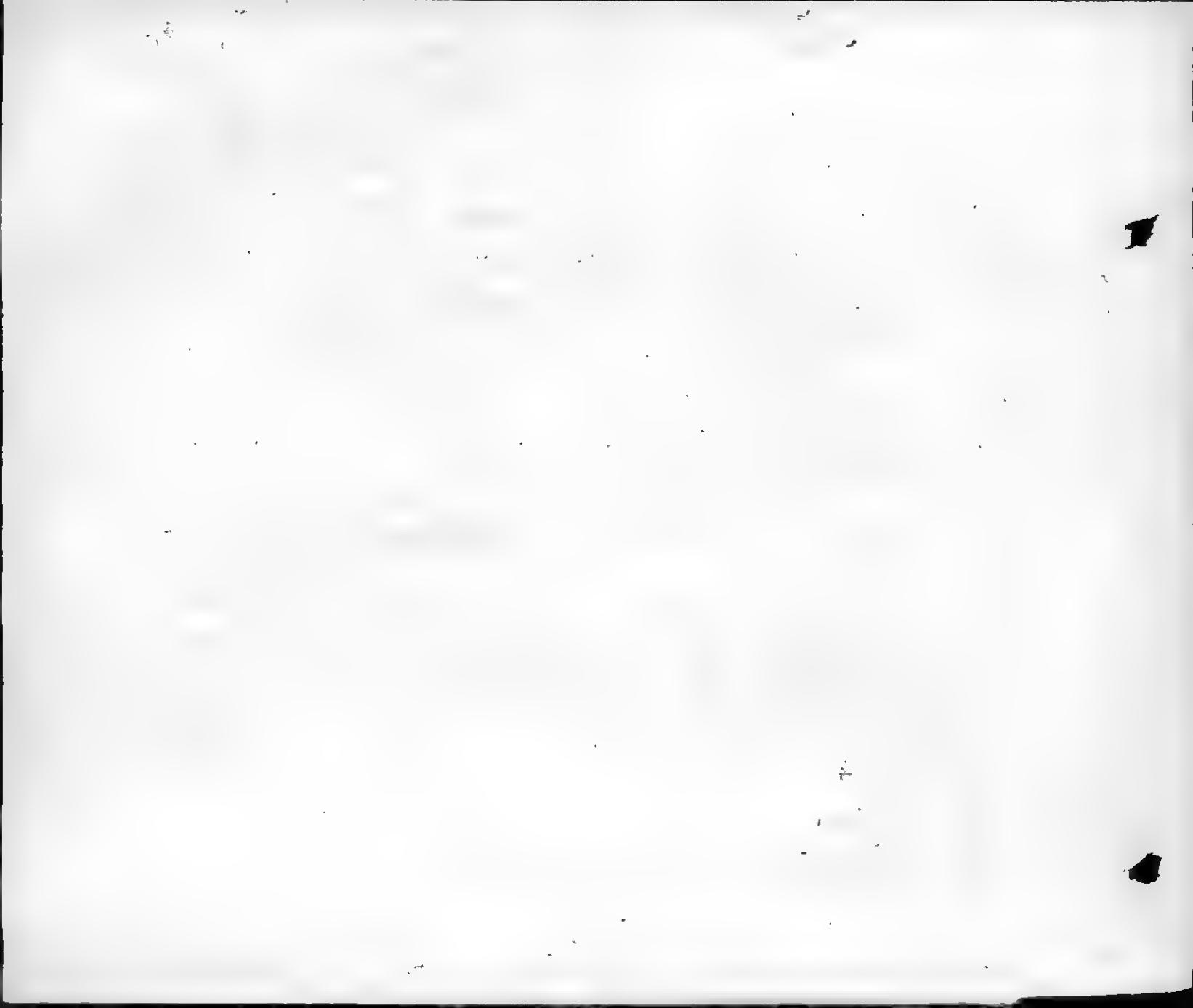
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5457

CERTIFICATE OF DEATH

05433

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural (Catonsville)		c. LENGTH OF STAY IN 1b 7 Weeks.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Brook Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dorothy		First D	Middle Daugherty
Last Engelhardt		4. DATE OF DEATH May, 14	Month Year 1960
5. SEX FEMALE	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Eshbach		14. MOTHER'S MAIDEN NAME Annie Dean	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO (If yes, give war & dates of service) 215-10-21620	17. INFORMANT Harry Daugherty 3816 Cedar Drive	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH 8 hrs.		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. , 19 60 , to May , 19 60 , that I last saw the deceased alive on May 19 , 19 60 , and that death occurred at 10:10 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Daniel BAKAL PHYSICIAN'S NAME (Type) DANIEL BAKAL			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/18/60	22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE George L. Schwab Funeral Home ADDRESS Francis W. Miller 2101 Frederick Ave.	24a. REC'D BY REGISTRAR DATE MAY 18 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05434

1. PLACE OF DEATH

a. COUNTY

BALTIMORE

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

(GARRISON) Pikesville

c. LENGTH OF STAY IN 1b

1b

YRS

d. NAME OF HOSPITAL (If not in hospital, give street address)

FOR INSTITUTION

Foxworth Nursing Home

2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission)

a. STATE

Md.

b. COUNTY

BALTIMORE

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Rural

d. STREET ADDRESS

6 Reservoir Rd.

1 Ettinger St. Baltimore, Md.

e. IS RESIDENCE

ON A FARM?

YES NO 3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE

OF

DEATH

Month

May

Year

Day

31

Year

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years

last birthday)

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. BIRTHPLACE (State or foreign country)

10a.

11.

12.

13. FATHER'S NAME

George F. Ensor

14. MOTHER'S MAIDEN NAME

Alice Rosier

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

yes

World War I

16. SOCIAL SECURITY NO

17. INFORMANT

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
give rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

ARTERIOSCLEROTIC ENCEPHALOPATHY

GENERALIZED ARTERIOSCLEROSIS

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			

21. I certify that (I) (this hospital) attended the deceased from November 1958 to May 1960, that (I) (we) last saw the deceased alive on 5-10-1960, and that death occurred at 7 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Francis T. Daly

M.D.

ATTENDING PHYS

MED DIRECTOR STAFF PHYS. 22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

FRANCIS T. DALY

22d. ADDRESS

1725 Reservoir Rd., Baltimore, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

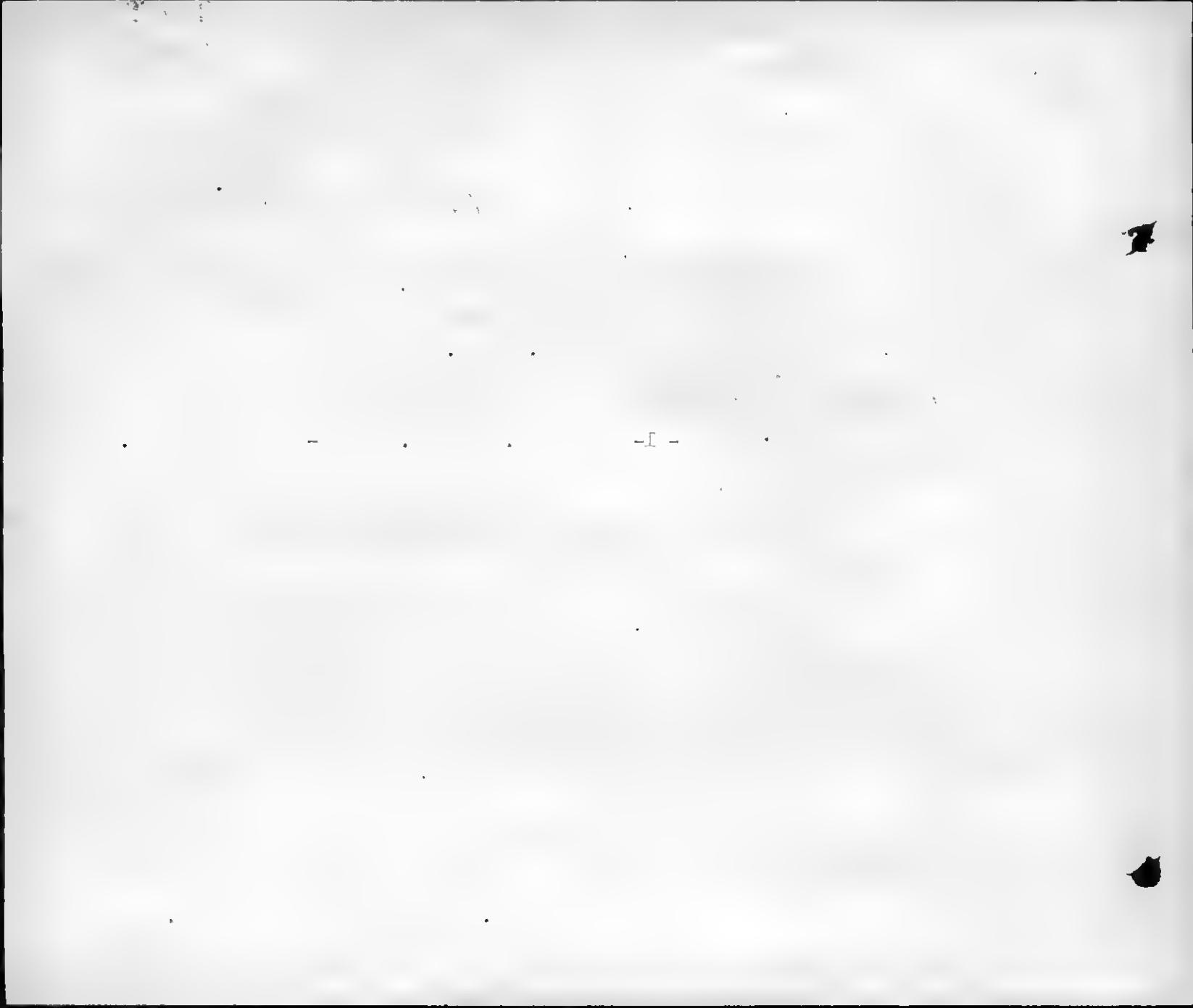
6/3/60

23b. DATE THEREOF

6/3/60

23c. NAME OF CEMETERY OR CREMATORIAL

Mt. Hebron Cemetery



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

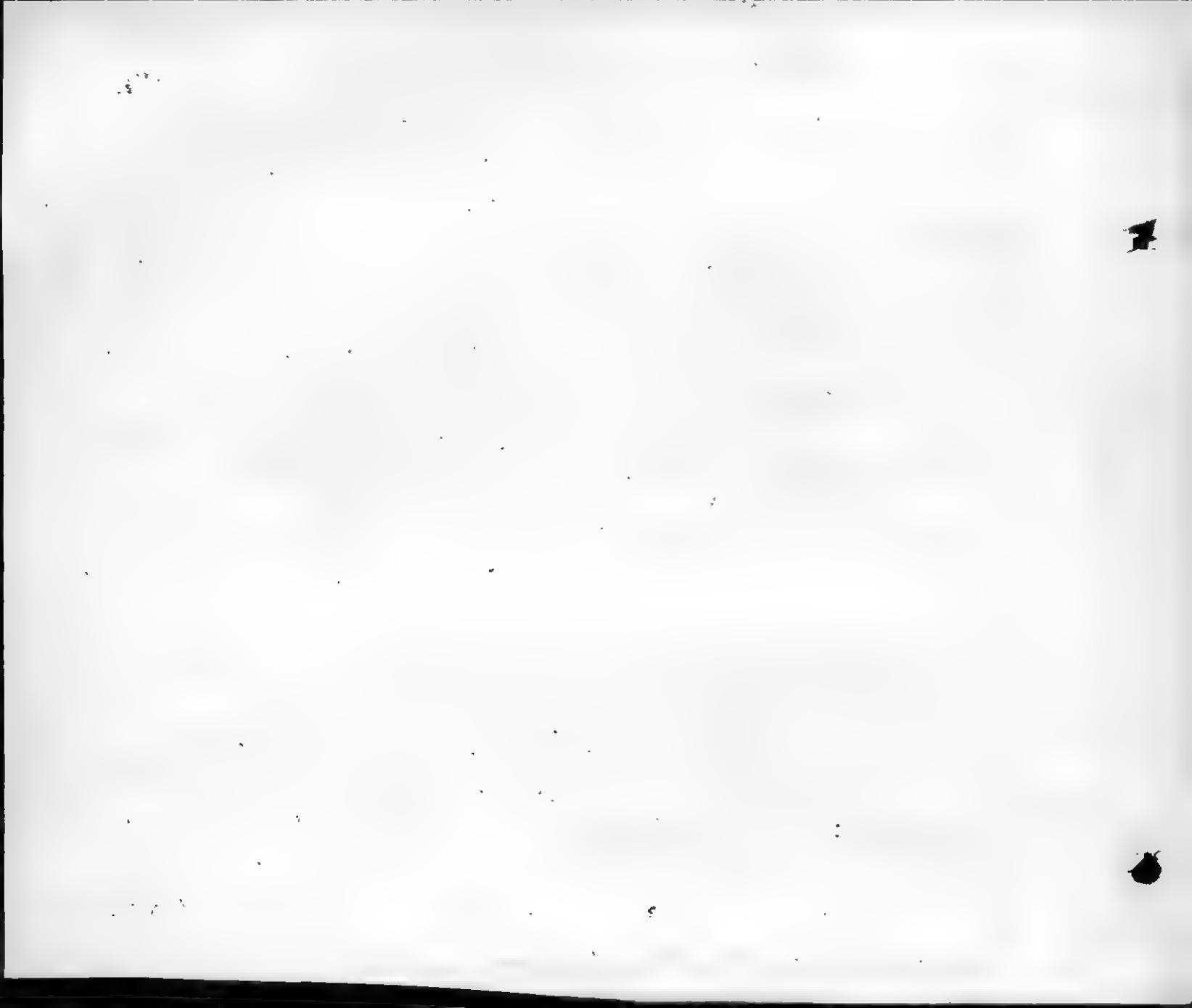
5459

CERTIFICATE OF DEATH

05435
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OVERlea.		c. LENGTH OF STAY IN 1b 30 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6801 BELAIR ROAD #6.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OVERlea	
3. NAME OF DECEASED (Type or print) ESTELLA		First ESTELLA	Middle MAR.
4. DATE OF DEATH MAY 24 1960		Month MAY	Day 24
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH DEC 18, 1892		9. AGE (In years lost birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. MOTHER'S MAIDEN NAME NETTIE EBERTS	
14. FATHER'S NAME EDWARD BECK		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO 218-26-5916		17. INFORMANT RUSSELL C. Fatzinger	18. ADDRESS 4218 CARDWELL AVE #6.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 472 Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause first. Hyper. Tension cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
DUE TO (b) Arterio. occlus. de.		DUE TO (c) Arterio. occlus. de.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1, 1953 to May 28, 1960 , that I last saw the deceased alive on May 22, 1960 , and that death occurred at 10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE RICHARD RIGLE		ADDRESS (Street, city or town, state) 1420 E. 36th St. BALTIMORE 6, MD.	
PHYSICIAN'S NAME (Type) RICHARD RIGLE		DATE SIGNED May 30, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF MAY 28, 1960	
22c. NAME OF CEMETERY OR CREMATORIAL GREENMOUNT CEM.		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND.	
23. FUNERAL DIRECTOR'S SIGNATURE ASSAHL Funeral Home 6801 Belair Road		24a. REC'D BY REGISTRAR # DATE 6. MAY 31 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

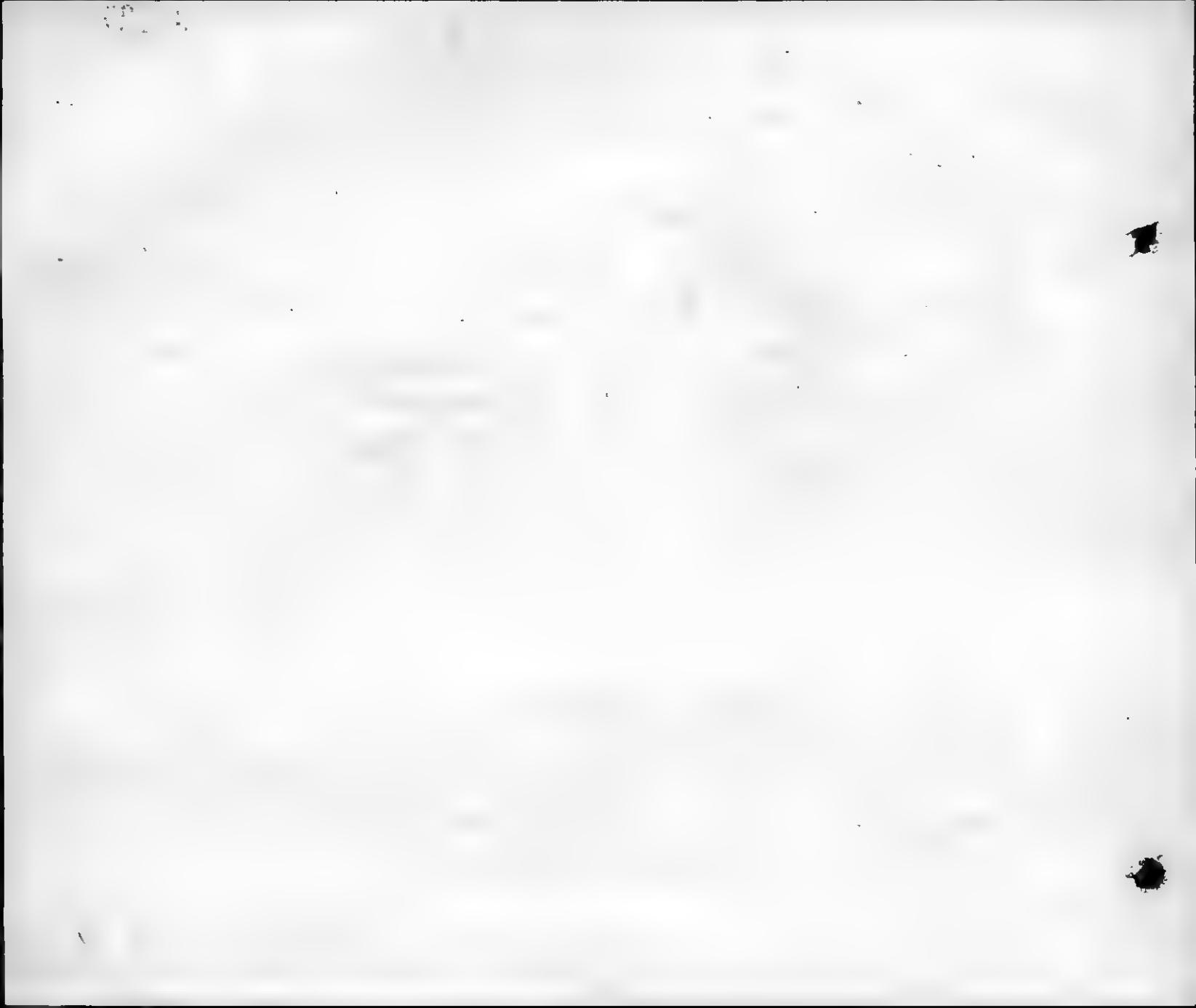
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 8 & 14 File G62 5/12/60 1wk

CERTIFICATE OF DEATH

05436
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		5460 Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Md			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Md			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		House in Pines		d. STREET ADDRESS		Baltimore			
3. NAME OF DECEASED (Type or print)		First ESTHER	Middle	Last FELDMAN	4. DATE OF DEATH	Month 5	Day 7	Year 1960	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)		
Female white					1086	74 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
House wife				Russia		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
David Goldowar		Freida		unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address			
				Samuel Weissman - same					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute Coronary Thrombosis</i> DUE TO <i>420.</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs.</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Cardio-Vascular Disease</i> DUE TO <i>107r.</i> (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY		Month	Day	Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
Hour a. m.				19	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				
21. I certify that I attended the deceased from <i>4-19-</i> , 19 <i>60</i> , to <i>5-7-</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>5-7-</i> , 19 <i>60</i> , and that death occurred at <i>6:30A.M.</i> from the causes and on the date stated above.									
ADDRESS (Street, city or town, state)									
ACTUAL SIGNATURE <i>Wilmer K. Gallagher</i> M.D. <i>6209 Frederick Ave.</i> DATE SIGNED <i>5-7-60</i>									
PHYSICIAN'S NAME (Type)		Wilmer K. Gallagher M.D.		Baltimore 25, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)	
removal		5-7-60				New York		<i>71-48</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
<i>Jack Lewis</i>		<i>2100 Eutaw Place</i>		DATE <i>MAY 9 '60</i>		<i>Arthur S. Kline</i>			



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5461

CERTIFICATE OF DEATH

05437
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kingsville</i>		b. COUNTY <i>Baltimore</i>	
c. LENGTH OF STAY IN 1b <i>7 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kingsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		d. STREET ADDRESS <i>Sunshine Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Harry Amos Fitch</i>		4. DATE OF DEATH <i>May 12 1960</i>	Month Day Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 27 1887</i>
9. AGE (In years, less birthday) <i>72 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS Hours <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm.</i>	
11. BIRTHPLACE (State or foreign country) <i>Fullerton, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John. B. Fitch</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Syppel</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or status of service) <i>No</i>		16. SOCIAL SECURITY NO <i>218-18-0885</i>	
17. INFORMANT <i>Mary Irene Fitch</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro Atherosclerosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20a. TIME OF INJURY Month, Day, Year Hour, a. m. p. m. <i>May 12 1960</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State) <i></i>	
21. I certify that I attended the deceased from <i>March 10 1960</i> to <i>May 12 1960</i> , that I last saw the deceased alive on <i>May 12 1960</i> , and that death occurred at <i>445 M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Kingsville</i> DATE SIGNED <i>5-12-60</i>			
ACTUAL SIGNATURE <i>William A. Tyson</i> M.D.			
PHYSICIAN'S NAME (Type) <i>WILLIAM A. TYSON</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/14/1960</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Jarrettsville</i>		22d. LOCATION (City, town, or county) (State) <i>Jarrettsville Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles E. Kurtz</i>		24a. REG'D BY REGISTRAR DATE <i>MAY 17 '60</i>	
ADDRESS <i>Jarrettsville Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, ~~cremation~~, removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5462

CERTIFICATE OF DEATH

05438
Reg. Dist. No.

Reg. U.S. Pat. & Tm. Off.

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland b. COUNTY											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 7 mth 21 ddays		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore										
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL			d. STREET ADDRESS Mt. Royal Avenue (1335)			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Thomas		First Middle Last Thomas John Foley		4. DATE OF DEATH MAY 28 1960		Month Day Year								
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 27, 1889		9. AGE (In years) IF UNDER 1 YEAR 70 yrs.			IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) contractor		10b. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.								
13. FATHER'S NAME Unknown T. J. Foley			14. MOTHER'S MAIDEN NAME Ellen Williams											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown No			16. SOCIAL SECURITY NO. 159-10-6862			INFORMANT Records: SPRING GROVE STATE HOSPITAL			Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Bronchopneumonia						INTERVAL BETWEEN ONSET AND DEATH 75 days					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			DUE TO (b) Arteriosclerotic Cardiovascular Disease Unknown											
DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)											
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from May 13, 1959, to May 26, 1960 that I lost saw the deceased alive on May 27, 1960, and that death occurred at 1:45 P.M. from the causes and on the date stated above.												ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL		
ACTUAL SIGNATURE Edward T. Johnson			M.D.			DATE SIGNED Catonsville 28, Maryland								
PHYSICIAN'S NAME (Type)														
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-31-60		22c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery			22d. LOCATION (City, town, or county) Chestertown, Md							
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street			ADDRESS			24a. REC'D BY REGISTRAR JUN 1 '60			24b. REGISTRAR'S SIGNATURE Clinton L. Hause					



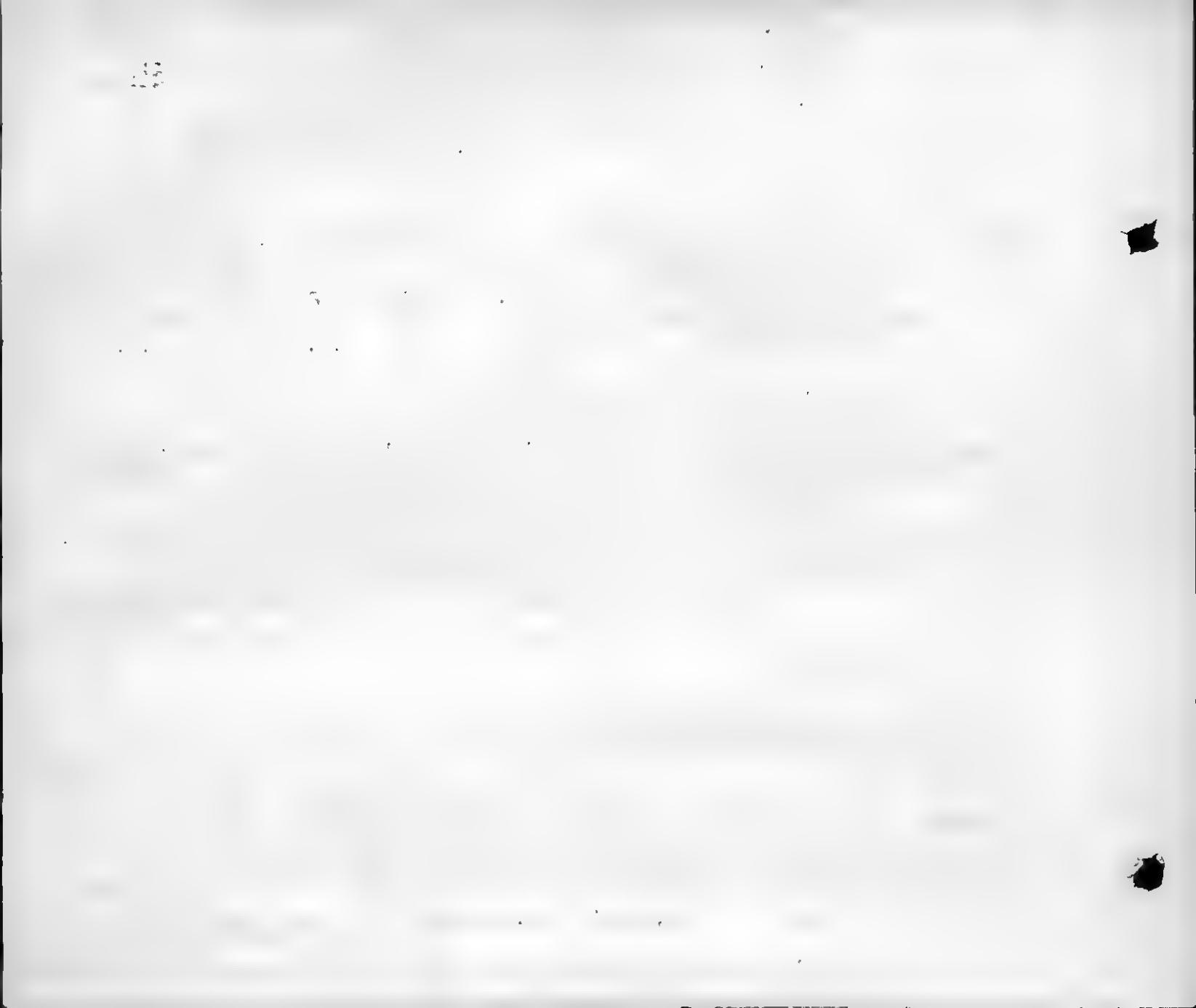
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

5463 CERTIFICATE OF DEATH

05439

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ellerslie Farm			d. STREET ADDRESS Ellerslie Farm				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Pearl Ann Peatly		First	Middle	Last	4. DATE OF DEATH Month May Day 4 Year 1960		
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1884 Aug. 5, 1887		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John P. Ahern			14. MOTHER'S MAIDEN NAME Clorinda West				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Mrs. John Brice, 424 Rosebank Avenue		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c) DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 12 yrs. 5 yrs. 5 yrs. ?							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) Frederick	(County) Md	(State) Md	
21. I certify that I attended the deceased from <u>11. 24</u> , 19 <u>55</u> , to <u>30. 5. 4</u> , 19 <u>60</u> that I last saw the deceased alive on <u>5. 2</u> , 19 <u>60</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>George E. Urban</u> M.D. ADDRESS (Street, city or town, state) <u>805 Frederick Ave 28 Md</u> DATE SIGNED: <u>5. 4. 60</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5-7-60	22c. NAME OF CEMETERY OR CREMATORIAL St. Paul's P.E. Cemetery	22d. LOCATION (City, town, or county) Chestertown, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street			ADDRESS	24a. REC'D BY REGISTRAR DATE MAY 9 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline		



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.

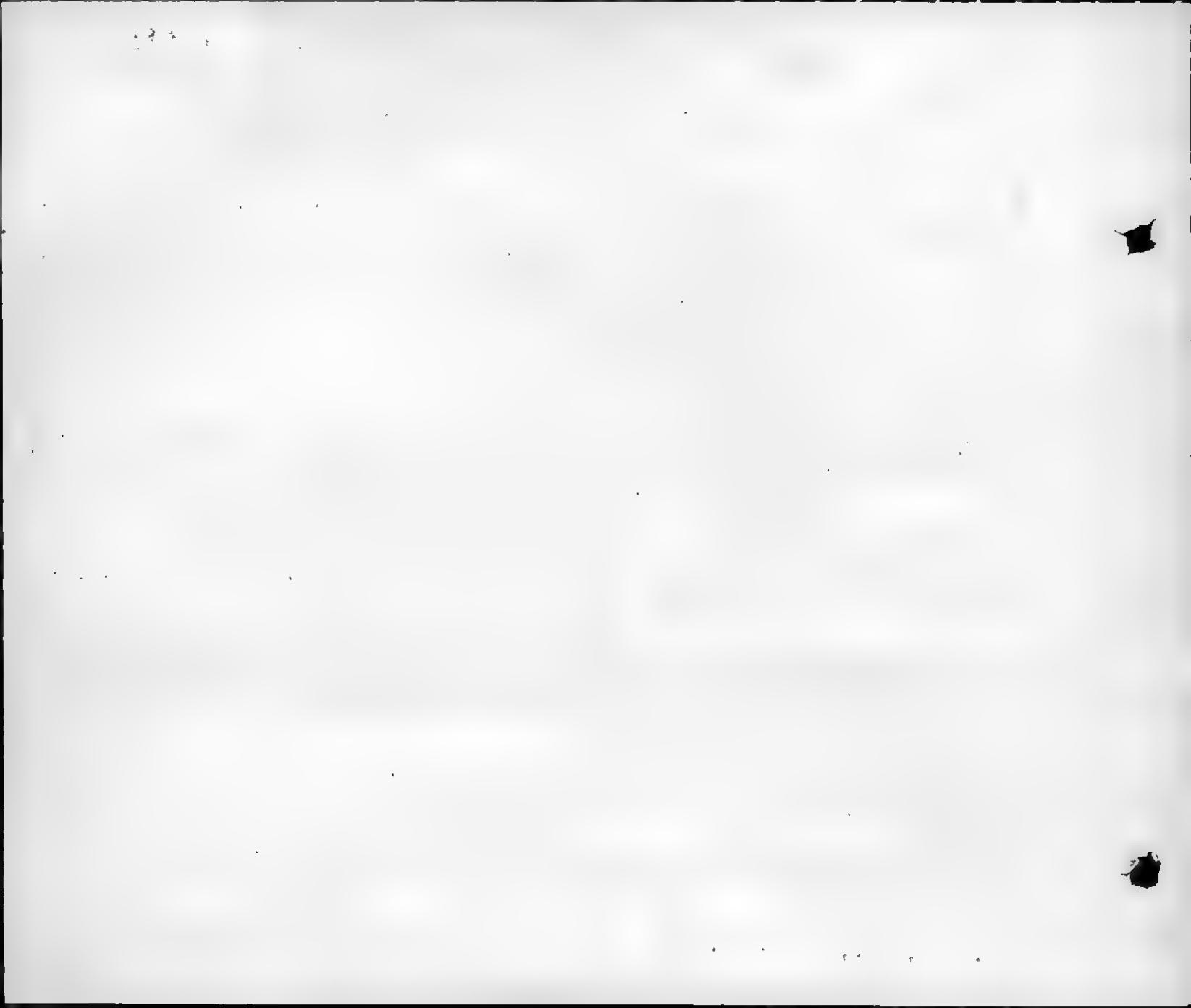
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

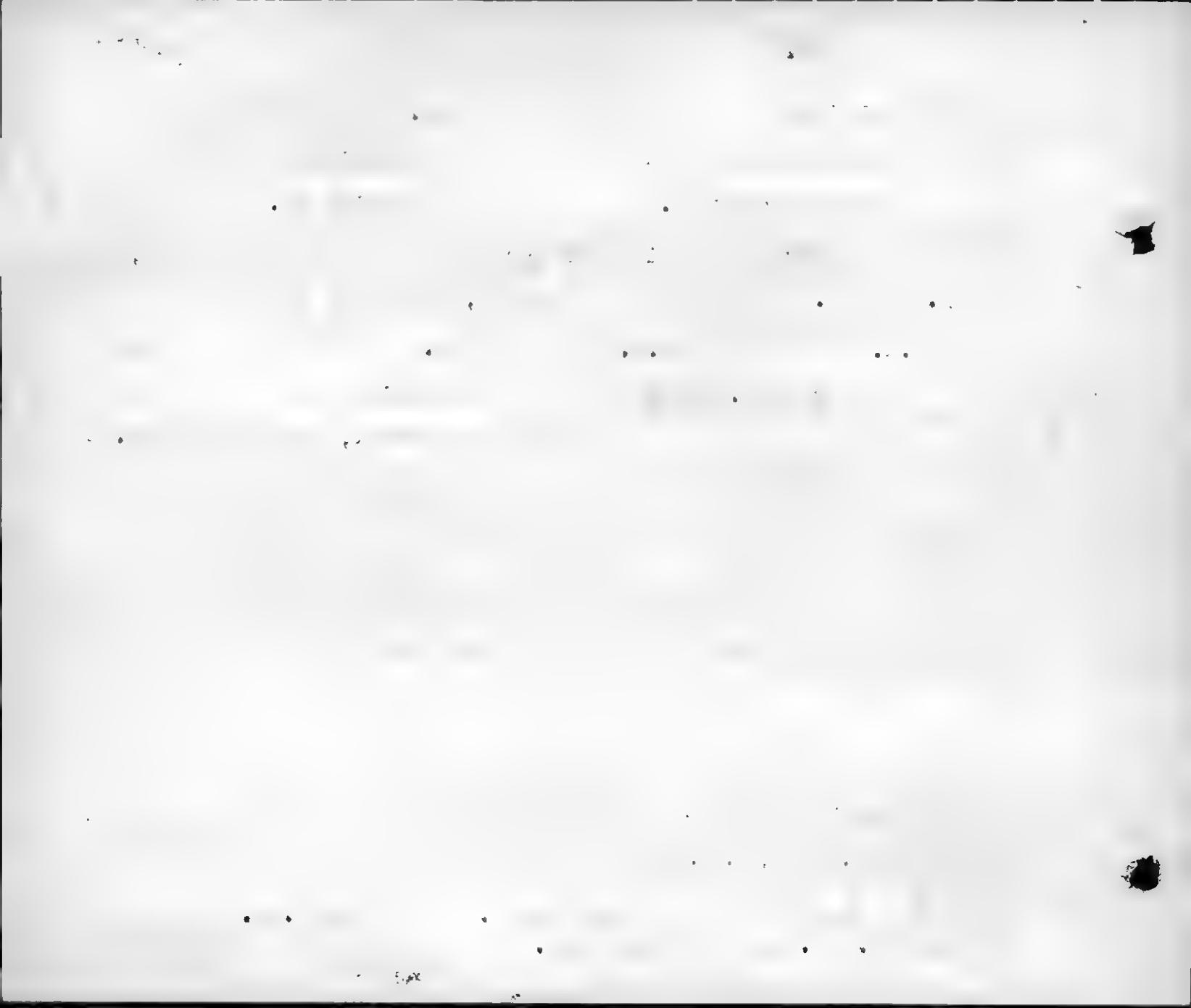
Item 9 Film 0262 7/17/60 iwk 115440

1. PLACE OF DEATH a. COUNTY		Baltimore Maryland		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE		MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 18 YEARS - 7 mo		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		b. COUNTY		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		d. STREET ADDRESS 9 SOUTH LINWOOD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First ANNA	Middle P	Last FRANKLIN	4. DATE OF DEATH	Month MAY	Day 5	Year 1960
S SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 1, 1875		9. AGE (In years last birthday) 74 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME JOSEPH CLEMSON		14. MOTHER'S MAIDEN NAME MARY AULD						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown; If yes, give war or dates of service) No		16. SOCIAL SECURITY NO NONE		17. INFORMANT Frank L. Smith Jr. Cockeysville, Md		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 18c. 1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		Cornary Occlusion				INTERVAL BETWEEN ONSET AND DEATH		
(b) DUE TO		Cornary Occlus - Sclerosis						
(c) DUE TO		Arterio Occlusive Cardio Vascular Disease		18 yrs.				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
19								
21. I certify that (I) (this hospital) attended the deceased from 5-20, 1949, to 5-5, 1960, that (I) (we) last saw the deceased alive on 5-5, 1960, and that death occurred at 8:40 AM, from the causes and on the date stated above.								
22a. SIGNATURE Walter T. Kees		MD		ATTENDING PHYS <input type="checkbox"/>	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 5/5/60	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEEPS		22d. ADDRESS COCKEYSVILLE MD						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-9-60		23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery		23d. LOCATION (City, town, or county) Baltimore (State)		
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		ADDRESS + street		25a. REC'D BY REGISTRAR DATE MAY 9 '60		25b. REGISTRAR'S SIGNATURE Cathleen S. Nease		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4
 may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										05441				
5465					CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 10 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 330 Greenlow Rd.					d. STREET ADDRESS 330 Greenlow Rd.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mary		First Elizabeth		Middle Garnett		4. DATE OF DEATH May 21, 1960				Month	Day	Year		
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 4, 1882		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.					10b. KIND OF BUSINESS OR INDUSTRY O.H.					11. BIRTHPLACE (State or foreign country) Md.				
12. CITIZEN OF WHAT COUNTRY? USA														
13. FATHER'S NAME Charles F. Graves					14. MOTHER'S MAIDEN NAME Katherine									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Miss Pat Garnett, 330 Greenlow Rd. #28				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)												Myocardial Insufficiency Arteriosclerotic cardio vascular disease		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Feb. 9, 1960 to May 21, 1960 , that (I) (we) last saw the deceased alive on May 18, 1960 , and that death occurred at 8:30 A.M. from the causes and on the date stated above												22b. DATE SIGNED May 23, 1960		
22c. PHYSICIAN'S NAME (Type) George A. Knipp, M. D.					M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>									
					22d. ADDRESS 4116 Edmondson Avenue									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 24/60		23c. NAME OF CEMETERY OR CREMATORIAL Mt Olivet Comt.			23d. LOCATION (City, town, or county) Balto. Md.			(State)				
24. FUNERAL DIRECTOR'S SIGNATURE Witzke Fun. Dir. 4101 Edmondson Ave.					ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE George A. Knipp		
										MAY 24 '60				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5466

CERTIFICATE OF DEATH

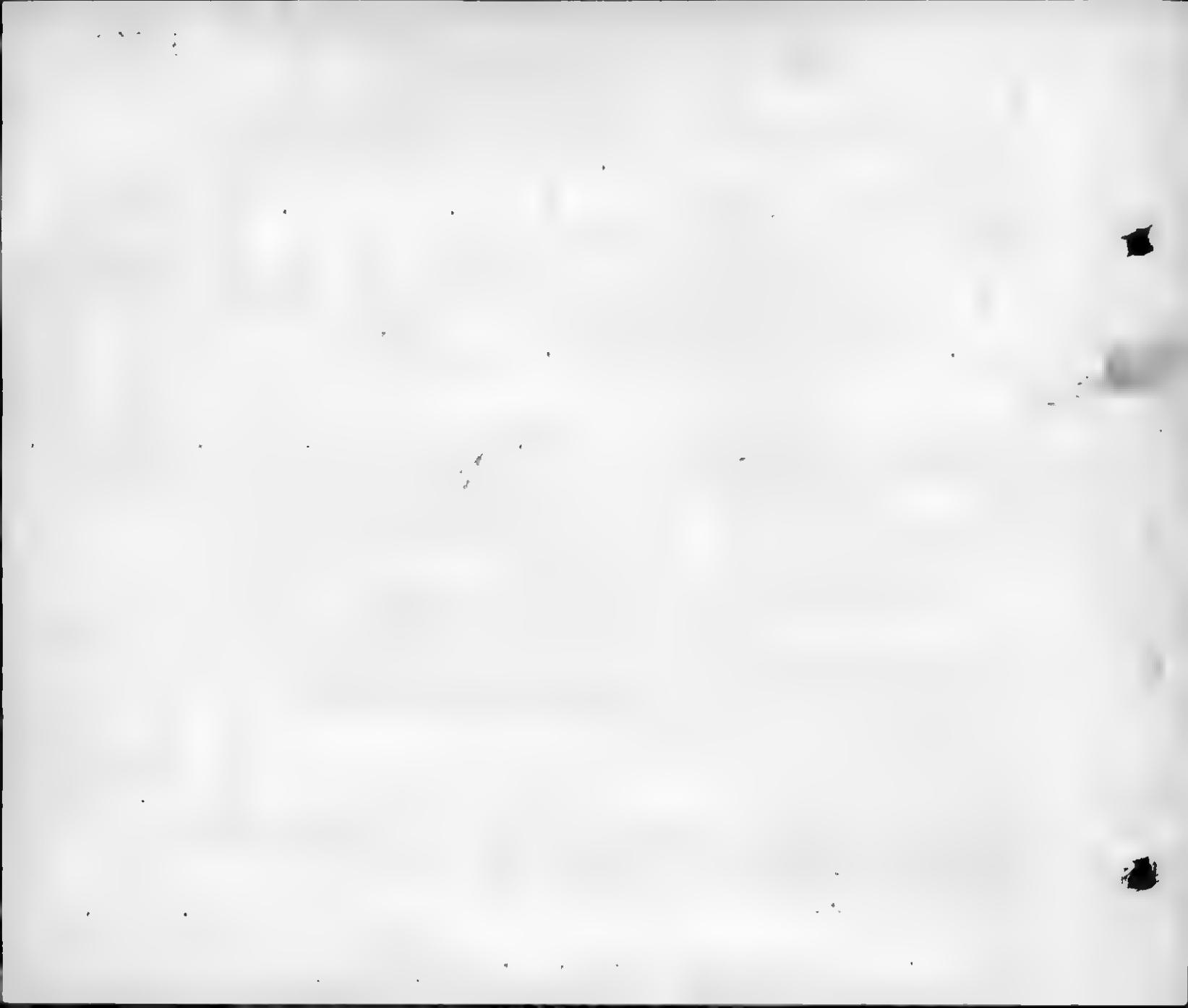
05442

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28		c. LENGTH OF STAY IN lb 7 Mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Conv. Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. STREET ADDRESS 328 S. Clinton St.		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sigmund Middle Gedrowicz		4. DATE OF DEATH Month May Day 5 Year 1960	
5. SEX Male White		6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH May 2, 1883		9. AGE (In years age birthday) yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Engineer		10b. KIND OF BUSINESS OR INDUSTRY Arundel Corp.	
10c. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? Poland	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Julia Gedrowicz 328 S. Clinton St.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-22-1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Generalized ASCV Disease (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 days 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/10/1960 to 5/15/1960, what I last saw the deceased alive on 5/15/1960, and that death occurred at 1 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE Joseph G. Laukaitis M.D. PHYSICIAN'S NAME (Type) JOSEPH G. LAUKAITIS MD		ADDRESS (Street, city or town, state) 679 W. Washington Blvd. Balt. 30 5/16/60 DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-7-1960	
22c. NAME OF CEMETERY OR CREMATORIAL Holy Rosary		22d. LOCATION (City, town, or county) German Hill Rd. (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda 2829 Hudson St. 24, Md.		24a. REC'D BY REGISTRAR DATE MAY 10 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5467

CERTIFICATE OF DEATH

05443

Reg. Dist. No.

1. PLACE OF DEATH
o COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Catonsville

c. LENGTH OF STAY IN 1b

39 yr 24 days

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

SPRING GROVE STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)

o. STATE

Maryland

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore

d. STREET ADDRESS

1722 Linden Avenue

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

May

10

19 60

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS

female

white

WIDOWED DIVORCED

1893

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

domestic

10b. KIND OF BUSINESS OR INDUSTRY

housework

11. BIRTHPLACE (State or foreign country)

Rumania

12. CITIZEN OF WHAT COUNTRY?

Rumania

13. FATHER'S NAME

Syncoski

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unknown)

(If yes, give war or dates of service)

unknown

16. SOCIAL SECURITY NO.

Unknown

17. INFORMANT

Records: SPRING GROVE STATE HOSPITAL

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Cardiac failure

INTERVAL BETWEEN
ONSET AND DEATH

DUE TO

422.1
Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause first.

(b)

DUE TO

Arteriosclerotic cardiovascular disease

(c)

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING

CAUSE OF DEATH

(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY
PERFORMED?
YES NO

20c. TIME OF INJURY Month, Day, Year

Hour

a. m.

p. m.

19

20d. INJURY OCCURRED

While at work Not while at work or work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from July 1, 1953, to May 10, 1960, that I last saw the deceased
alive on May 10, 1960, and that death occurred at 9:35 a. m., from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

M.D.

SPRING GROVE STATE HOSPITAL 5-19-60

PHYSICIAN'S
NAME (Type)

Bruno Radauskas, M. D.

Catonsville 28, Maryland

22a. FUNERAL, CREMATION, OR
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

(State)

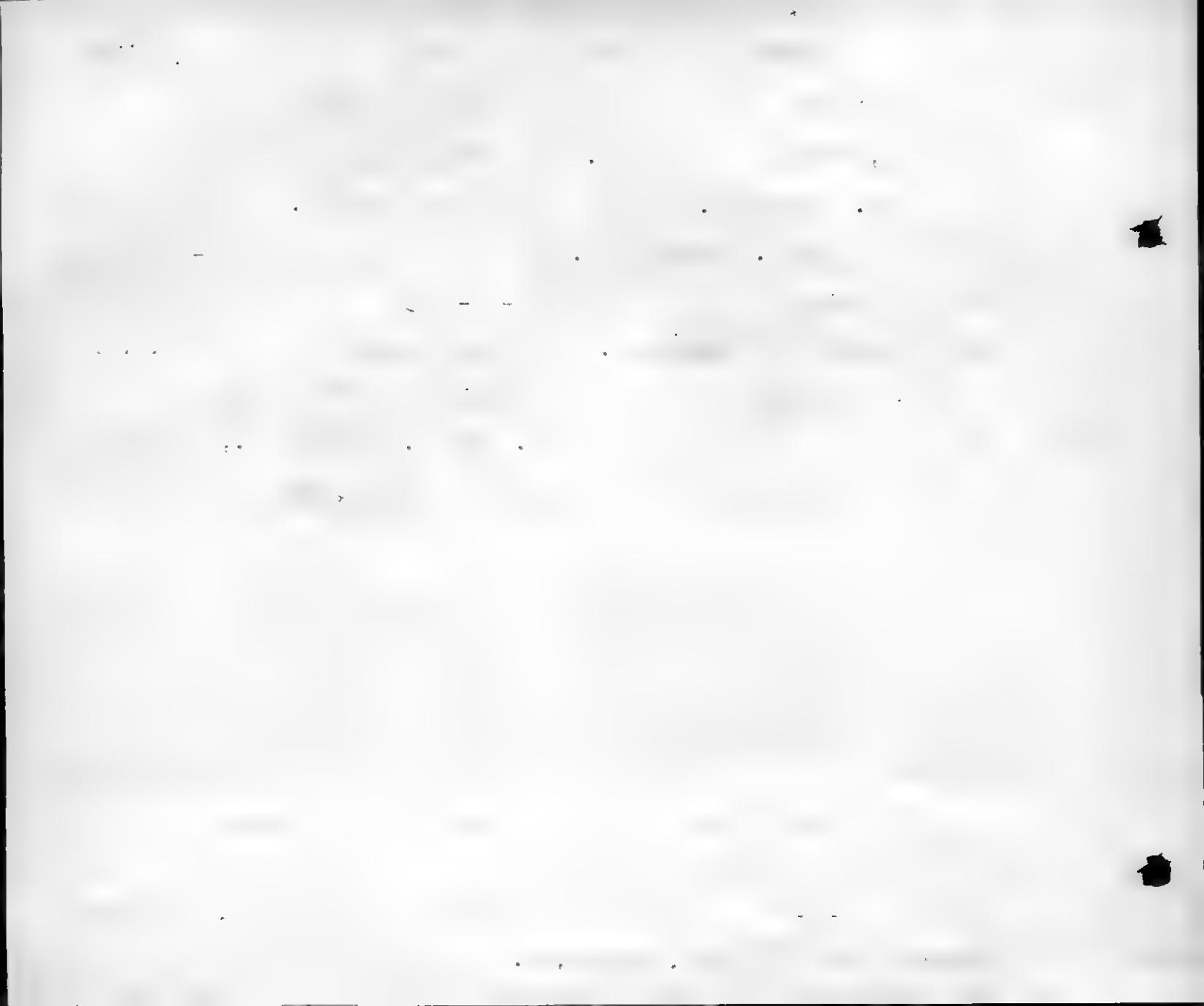
24b. REGISTRAR'S SIGNATURE

DATE

MAY 20 '60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
5468 CERTIFICATE OF DEATH 05444														
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived—If institution: Residence before admission) a. STATE New Jersey b. COUNTY										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkton, Rural				c. LENGTH OF STAY IN 1b 2 1/4 yrs.										
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Carmel Rd.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Jersey City										
3. NAME OF DECEASED (Type or print) John T. Glaccum, Sr.				First	Middle	Last	4. DATE OF DEATH 5-4-60	Month	Day	Year				
5. SEX male		6. COLOR OR RACE white		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12-21-1885			9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months		IF UNDER 24 HRS Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen'l manager				10b. KIND OF BUSINESS OR INDUSTRY glove X mfg.				11. BIRTHPLACE (State or foreign country) New Jersey				12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Glaccum				14. MOTHER'S MAIDEN NAME Julia ????? Mooney				Address						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.				INFORMANT						
								Mrs. John T. Glaccum Jr., above						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio sclerosis - generalized</i> DUE TO <i>450.0</i> INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs.</i>														
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Hour o. m. p. m.				Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)			
21. I certify that I attended the deceased from <i>Jas</i> , 19 <i>59</i> , to <i>May</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>May 3</i> , 19 <i>60</i> , and that death occurred at <i>3 A.M.</i> from the causes and on the date stated above.														
ACTUAL SIGNATURE <i>C. Herbert Mueller Jr.</i> M.D. ADDRESS (Street, city or town, state) <i>York Rd - Parkton P.O.</i> DATE SIGNED <i>5/4/60</i>														
PHYSICIAN'S NAME (Type) C. HERBERT MUELLER Jr.				PARKTON, P.O.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-7-60		22c. NAME OF CEMETERY OR CREMATORIUM Holy Name Cemetery				22d. LOCATION (City, town, or county) Jersey City, New Jersey (State)						
23. FUNERAL DIRECTOR'S SIGNATURE <i>Scott Brooks</i>		ADDRESS Brook Funeral Service, Towson, Md.		24a. REC'D BY REGISTRAR DATE MAY 5 '60				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>						

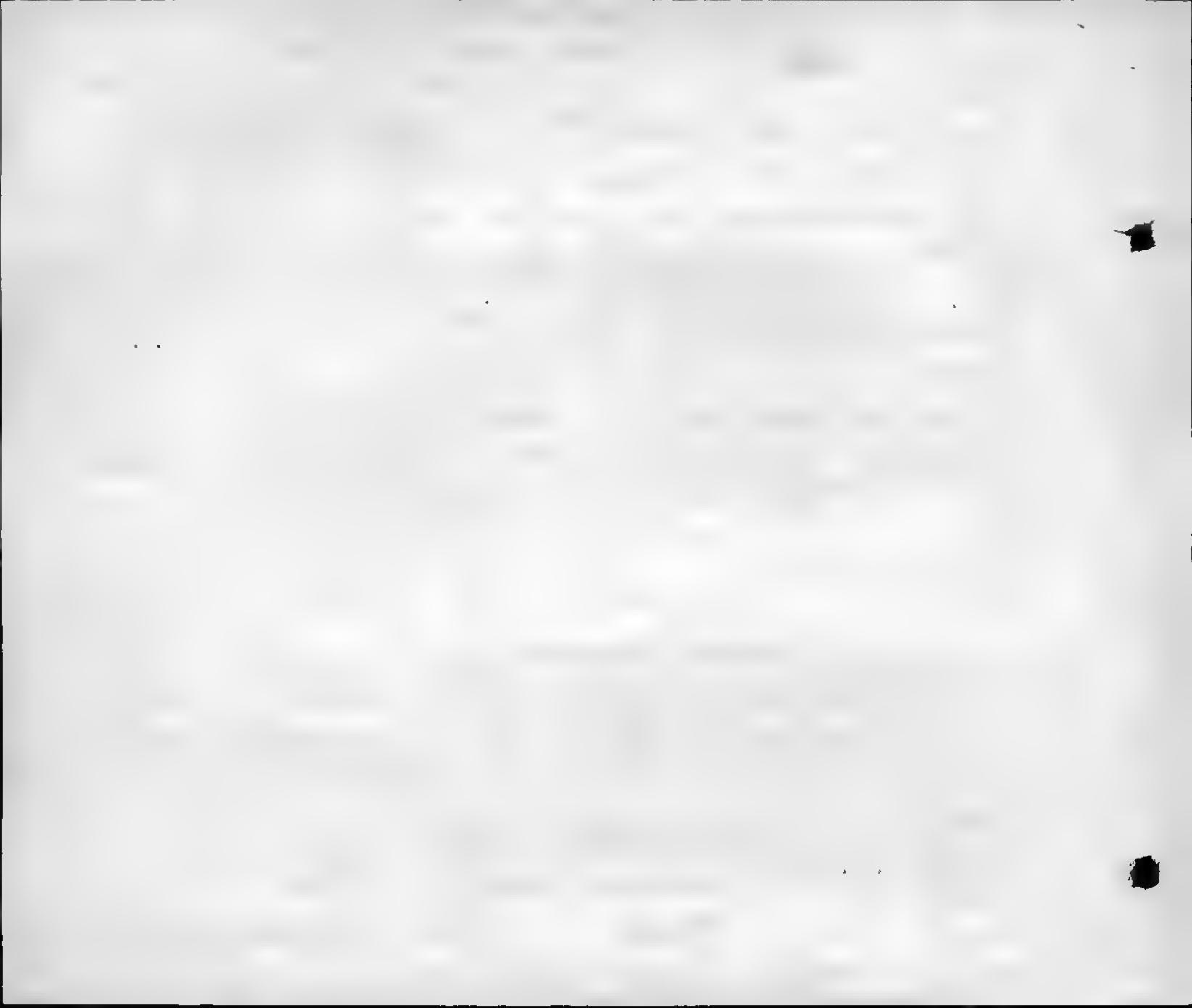


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
540 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06605
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
Baltimore MARYLAND		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne		c. LENGTH OF STAY IN lb	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne		d. STREET ADDRESS 2015 Hammond Ferry Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2015 Hammond Ferry Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Annie Sabina GLASER		4. DATE OF DEATH Month May 31, 1960	Day 19
5. SEX Fem. 6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> May 17, 1881	
9. AGE (In years old/birthday) 79 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. Smith		14. MOTHER'S MARRIED NAME Anne don't know	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 17. INFORMANT None ALFRED CONNOR 2909 Hemlock Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Address	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
(b) Cardio vascular heart disease			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. M. Kieffer		DATE SIGNED 1960	
EXAMINER'S NAME (Type) Dr. S. V. Kieffer M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Select)		22b. DATE THEREOF 6-4-60	
22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook - Blight, Inc. 6009 Maryland		24a. REC'D BY REGISTRAR DATE JUN 6 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kieffer	

TO DIRECTOR MEDICAL EXAMINER: This certificate should be ~~exhibited~~ within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 through 4 with the registrar prior to burial or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be signed by the hospital or attending physician.

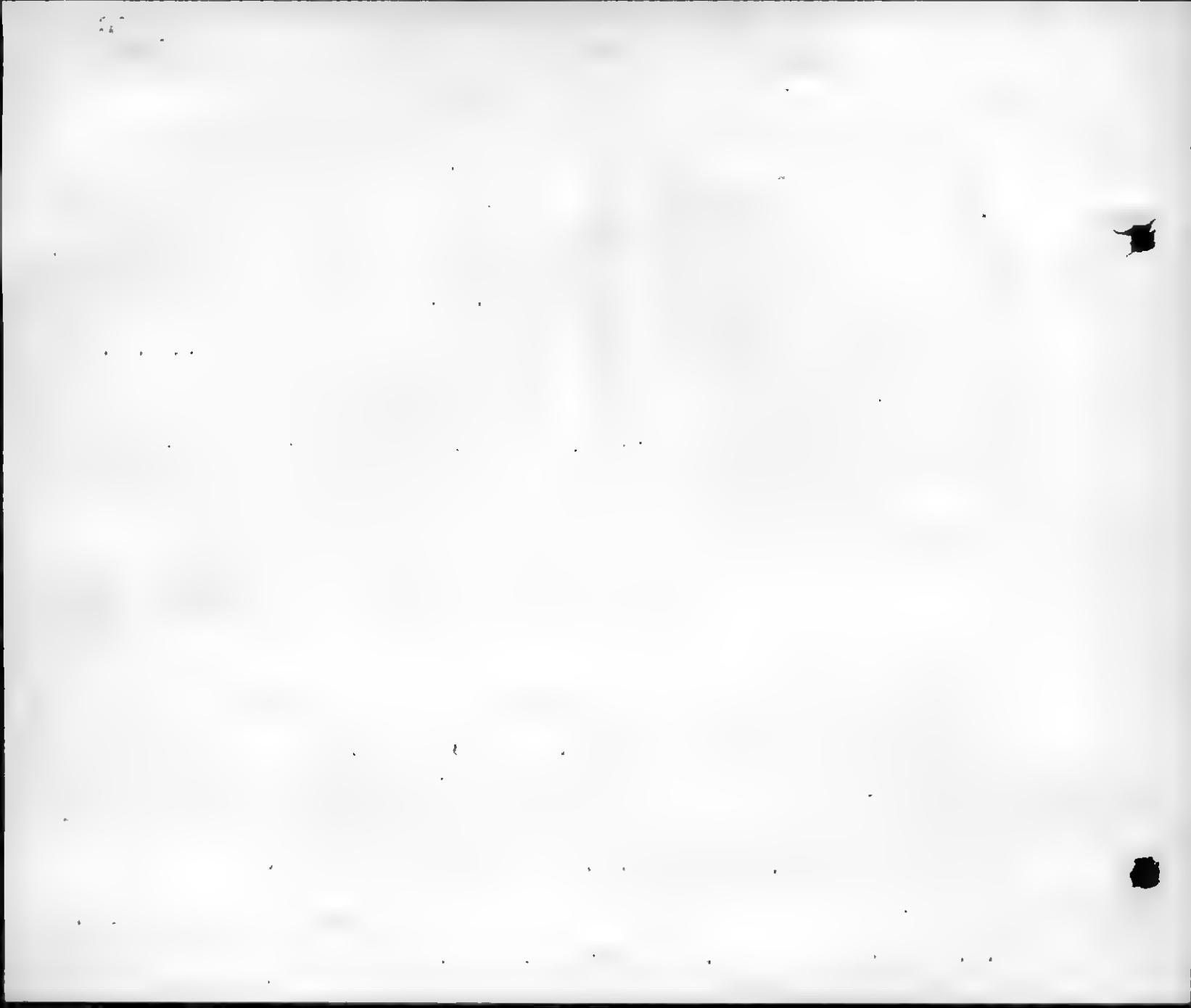
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. No. **15445**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Baltimore		b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 5yr 6mths 8dys	
Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1324 Bentallou Street	
SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First George	Middle Gogin
4. DATE OF DEATH		Month May	Day 12
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Jan. 24, 1891		9. AGE (In years last birthday) 69 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) chief engineer		10b. KIND OF BUSINESS OR INDUSTRY Merchant Marines	11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 1913 and 1944	INFORMANT Records: SPRING GROVE STATE HOSPITAL
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
177X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Cachexia	
DUE TO (b)		Generalized carcinomatosis	
DUE TO (c)		Prostate carcinoma	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____		Nov. 24, 1958, to May 12, 1960, that I last saw the deceased alive on May 12, 1960, and that death occurred at 11:15 p.m., from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>Anthony S. Garafano</i>		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL 5-13-60	
PHYSICIAN'S NAME (Type) Anthony S. Garafano, M. D.		DATE SIGNED	
22a. BURIAL, CREMATION REMOVAL (Specify) Cremation		22b. DATE THEREOF 5-16-60	22c. NAME OF CEMETERY OR CREMATORIAL Greenmount
22d. LOCATION (City, town, or county) Baltimore		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. W. Jenkins & Sons Co.		24a. REC'D BY REGISTRAR MAY 16 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur J. Moore</i>
4905 York Rd. Balt.		ADDRESS	



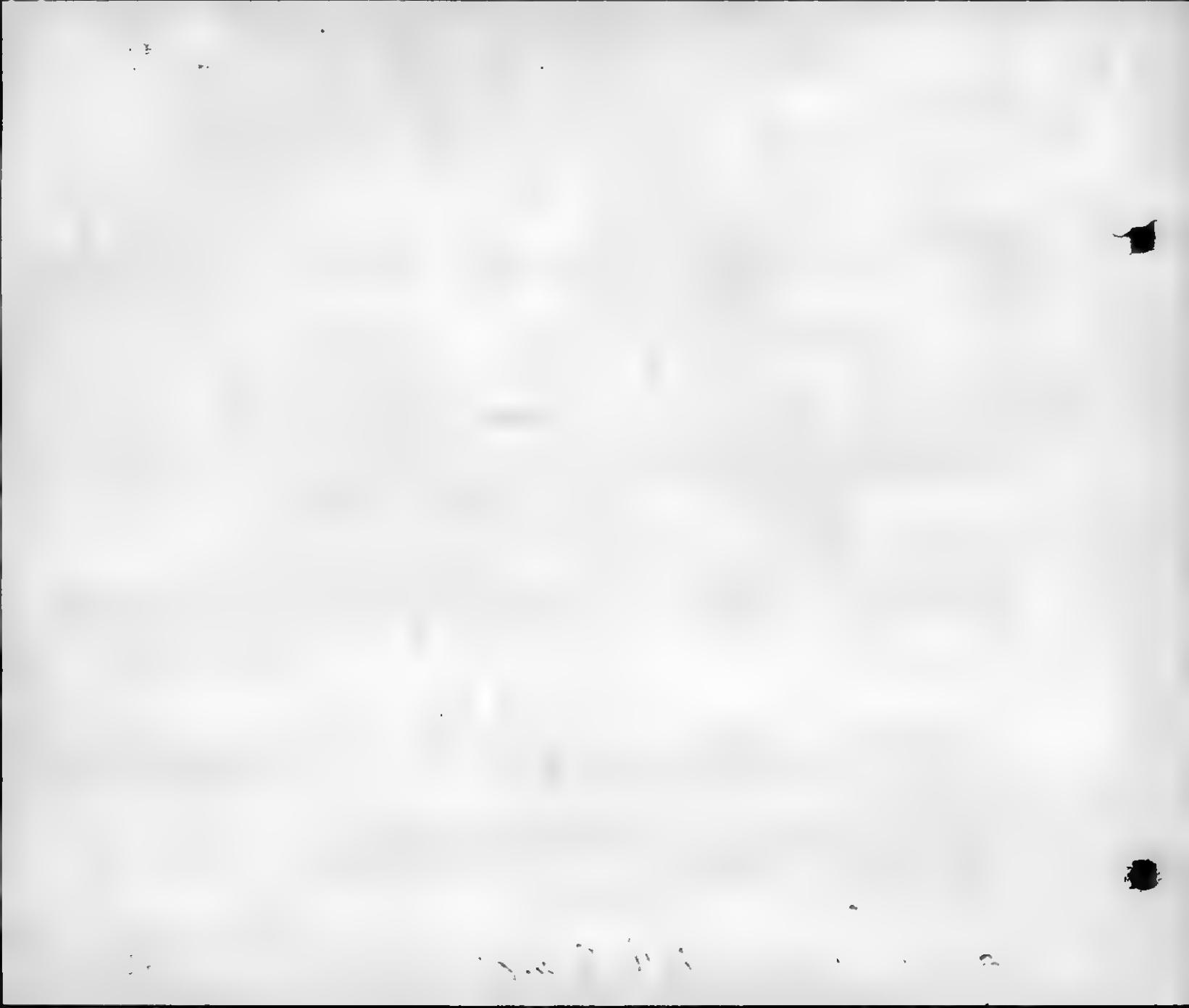
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
547 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05446

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Balt.		MD		Baltimore 28				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN b.		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Mt. Wilson		1 yr.		Mt. Wilson 28				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS		e. IS RESIDENCE ON A FARM?				
Mt. Wilson State Hosp.		1927. Baltimore Ave.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
BERNARD. ANTHONY GONCE					May	21	1960	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6-29-1910	49 yrs.	Months	Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Linotype operator		Record		Balt.		W. Soc		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
John H. Gonce		Corrine Ezrie						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No.		217-07-3935		Mt. Wilson Records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)								
476 DUE TO <u>Baltimore won't thru Head.</u> 5 min.								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
(b) DUE TO <u>mental Depression</u> 1 yr.								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
Renal Tuberculosis 14 yrs. Depression Self infliction								
20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
7:10 a.m.		May 21 1960	White	Not white	Mt. Wilson	Balt.	MD	
20g. AT WORK <input type="checkbox"/> AT HOME <input checked="" type="checkbox"/>								
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED				
J. D. Gaples		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		5-21-60				
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
J. D. GAPLES								
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		
Burial		1960		Cathedral Cem.		Baltimore 10f.		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
Frank J. Gable		10th & E. St.		MAY 24 '60		Cath. S. Chase		
				DATE				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any entry is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the registrar prior to burial, or removal.



5471

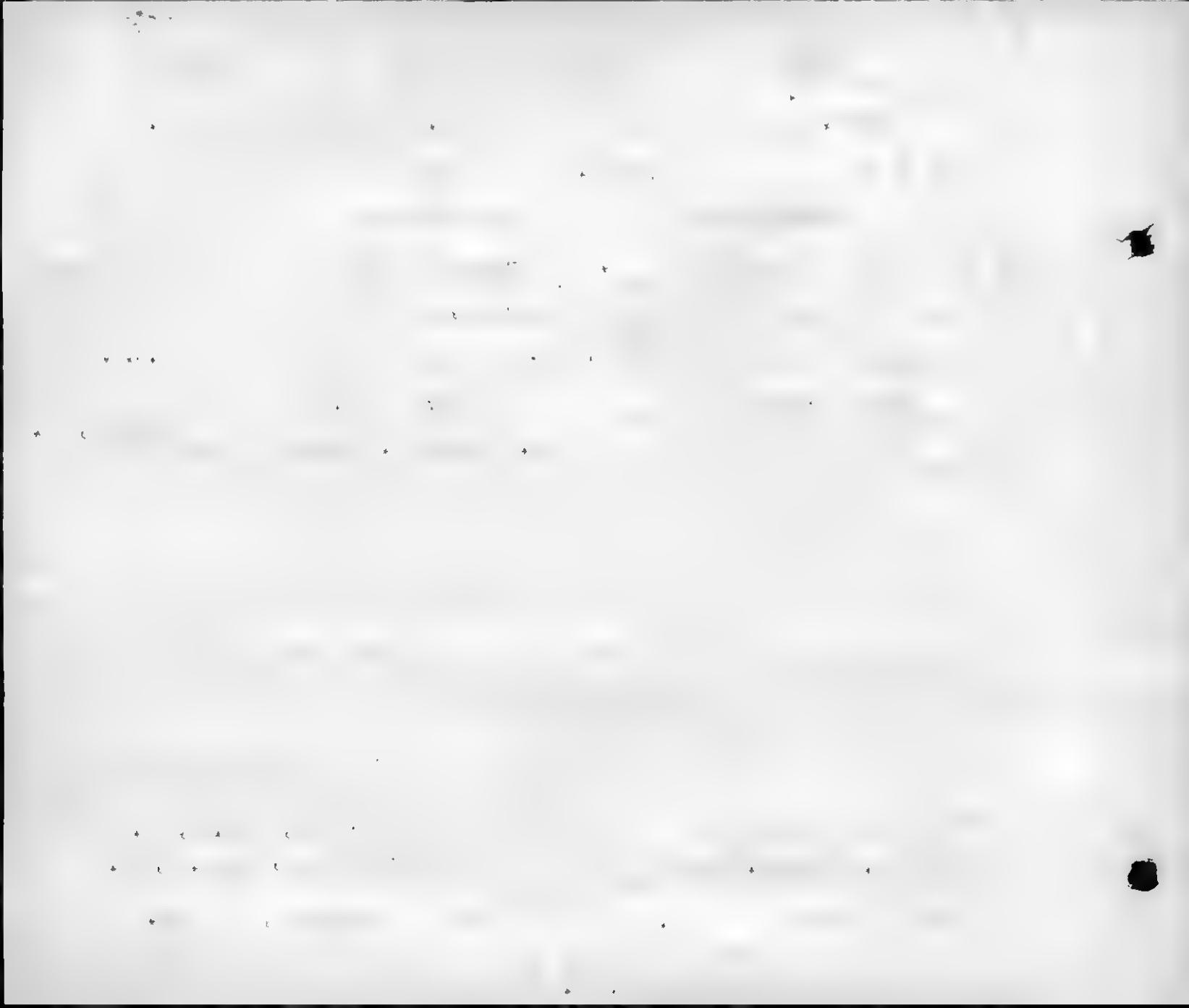
CERTIFICATE OF DEATH

Ref. 05447

may be obtained by the hospital or attending physician.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH a. COUNTY Baltimore			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md.						
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Woodstock		c. LENGTH OF STAY IN 1b 75 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodstock					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Court Road			d. STREET ADDRESS Old Court Road						
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print)	First Evariste	Middle A.	Last Graziani	4. DATE OF DEATH	Month 5	Day 22	Year 19 60		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED Married	8. DATE OF BIRTH March 9, 1870	9. AGE (In years last birthday) 90	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor			10b. KIND OF BUSINESS OR INDUSTRY LAUNDRY Woodstock College			11. BIRTHPLACE (State or foreign country) Italy			
13. FATHER'S NAME Anthony Graziani			14. MOTHER'S MAIDEN NAME Flavia						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No			16. SOCIAL SECURITY NO. *****			17. INFORMANT Mrs. Catherine M. Graziani			Address Woodstock, Md. Old Court Road
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1			Coronary thrombosis -						INTERVAL BETWEEN ONSET AND DEATH 1 day
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 			(b) Generalized severe arteriosclerosis -						20 years
(c) Severe peripheral vascular disease -									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 3601 Clifmar Road, Baltimore, Md.	(County) 7	(State) Md.	
21. I certify that I attended the deceased from MAY 1, 1958 to MAY 22, 1960 that I last saw the deceased alive on MAY 22, 1960 , and that death occurred at 6A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3601 Clifmar Road, Baltimore, Md.									
DATE SIGNED Thomas E. Wheeler, M.D.									
ACTUAL SIGNATURE Thomas E. Wheeler, M.D.									
PHYSICIAN'S NAME (Type) Dr. Thomas E. Wheeler									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/25/60	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Alphonsus Cemetery			22d. LOCATION (City, town, or county) Woodstock, Md.			(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LORING BYERS FUNERAL HOME 8728 Liberty Road			24a. REC'D BY REGISTRAR DATE MAY 31 '60			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5472 05448

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 6 Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1317 Ensor Street (2)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JOSEPH	Middle ---	Last GREEN, JR.	4. DATE OF DEATH May 27, 1960	Month May	Day 10	Year 1960
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1924	9. AGE (In years last birthday) 35 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Hours 0	IF UNDER 24 HRS Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Green, Sr				14. MOTHER'S MAIDEN NAME Emma Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 217-16-5038		17. INFORMANT Clin. Records, VAH, Balto. 18, Md. Ft. Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LOBAR PNEUMONIA INTERVAL BETWEEN ONSET AND DEATH 4 DAYS							
41 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last JAUNDICE		(b) DUE TO				UNKNOWN	
		(c) DUE TO		CIRRHOSIS OF LIVER		UNKNOWN	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? NO							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11:40 AM 5/10/1960 to 5:40 PM 5/10/1960 , that (I) (we) last saw the deceased alive on May 10 1960 , and that death occurred at P. M. from the causes and on the date stated above.							
22. SIGNATURE John D. Talbert, M.D.		M.D.		ATTENDING PHYS <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED 5/11/60
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.		22d. ADDRESS VAH, BALTO. 18, MD., FT. HOWARD DIVISION					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-16-60		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Rayner Sanders		ADDRESS 217 E. Preston St.		25a. REC'D BY REGISTRAR DATE MAY 17 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 FilmG201 6-6-bu et

5473

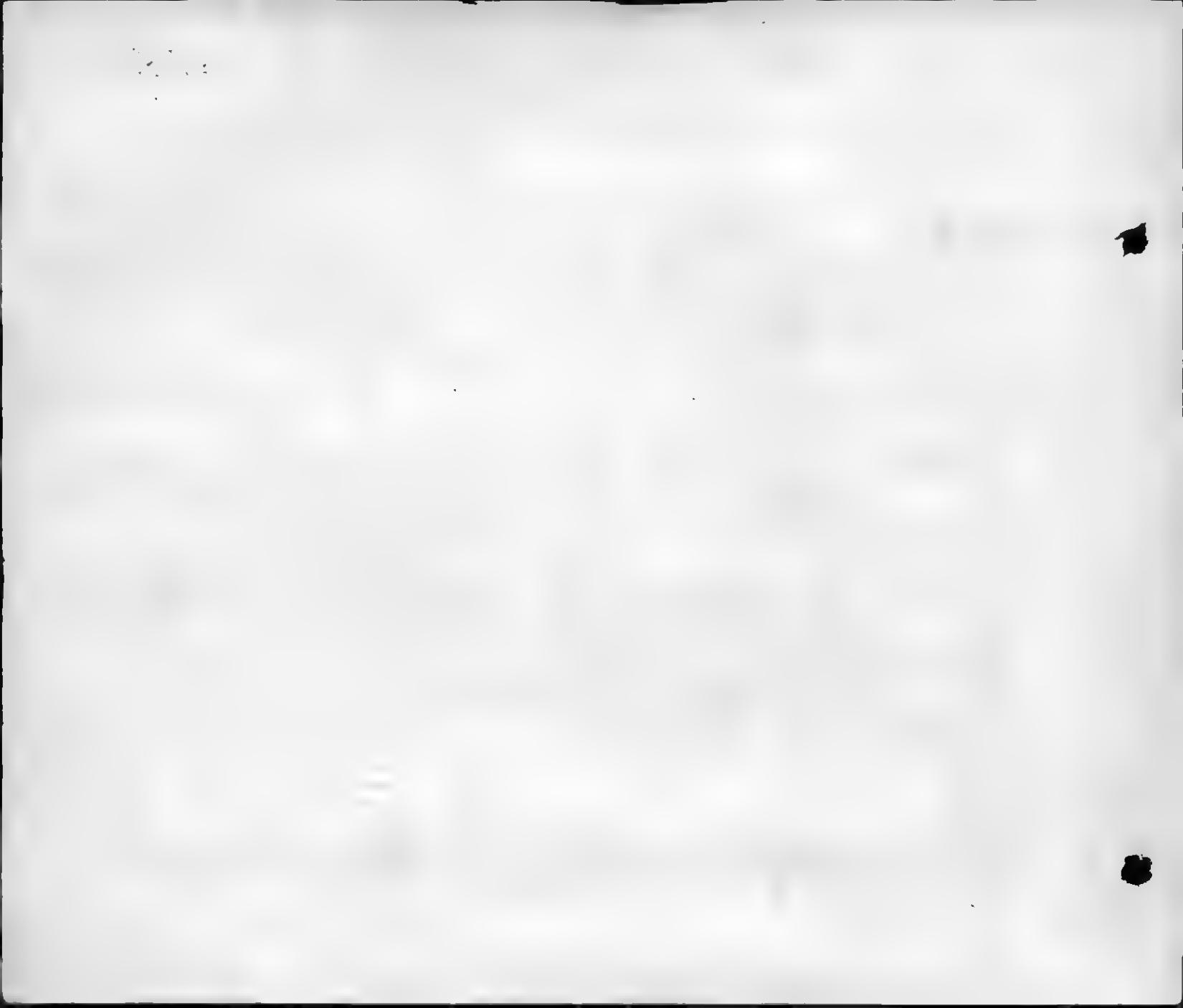
CERTIFICATE OF DEATH

Reg. Dist. No. 05449

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Colgate</i>		b. COUNTY	
c. LENGTH OF STAY IN 1b <i>1050 Old North Point</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Colgate</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1050 Old North Point</i>		d. STREET ADDRESS <i>1050 Old North Point</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Louisa</i>		First <i>Joe</i>	Middle <i>Hackett</i>
4. DATE OF DEATH <i>May 24 1960</i>		Month <i>May</i>	Day <i>24</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 31 1896</i>	
9. AGE (In years last birthday) <i>83</i>		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <i>0</i>	Days <i>0</i>
11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>? Helmar</i>		14. MOTHER'S MAIDEN NAME <i>Miss Lou E Hackett 1050 Old North Pt</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>153-0</i>	
17. INFORMANT <i>153-0</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Carcinoma of ascending Colon</i>	
DUE TO <i>Condition, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>	
DUE TO <i>(b)</i>			
DUE TO <i>(c)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>April 10, 1959</i> to <i>May 24, 1960</i> , that I last saw the deceased alive on <i>May 24, 1960</i> , and that death occurred at <i>1:50 PM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>1010 North Point Rd</i>	
ACTUAL SIGNATURE <i>Morris A. Jacobs</i>		DATE SIGNED <i>5/25/60</i>	
PHYSICIAN'S NAME (Type) <i>Morris A. Jacobs</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
22b. DATE THEREOF <i>5/27/60</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Clayton</i>	22d. LOCATION (City, town, or county) <i>Colgate Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ulmer Funeral Home - Standard</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 27 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>John S. Price</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4

ATTENDED BY
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 7 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										05450
5474		CERTIFICATE OF DEATH								
1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 1-1/2 HOURS								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE								
3. NAME OF DECEASED (Type or print) WILLIAM J. HANNIGAN		First	Middle	Last	4. DATE OF DEATH MAY 15 1960	Month	Day	Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 16, 1898	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.	
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY BALTO CO. TRANS. & RECORD DEPT		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME MICHAEL J. HANNIGAN		14. MOTHER'S MAIDEN NAME JULIA BURNS								
15. WAS DECEASED EVER IN J. S. ARMED FORCES? (Yes or No or Unknown) YES		16. SOCIAL SECURITY NO. WW-11 215-01-2005		17. INFORMANT CLIN REC VAH BALTIMORE MD-FT HOWARD DIVISION		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE HEMORRHAGE										
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) CARCINOMA OF LARYNX										
DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that CLOVIS M. SNYDER attended the deceased from May 15, 1960 to May 15, 1960 , that we last saw the deceased alive on May 15, 1960 , and that death occurred at 1:50 AM , from the causes and on the date stated above.										
22a. SIGNATURE Clov M. Snyder		M.D. ATTENDING PHYS <input type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 5-15-60		
22c. PHYSICIAN'S NAME (Type) CLOVIS M. SNYDER		22d. ADDRESS M.D. VAH BALTIMORE MD * FT HOWARD DIVISION								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-18-60		23c. NAME OF CEMETERY OR CREMATORIAL NEW CATHEDRAL CEMETERY		23d. LOCATION (City, town, or county) BALTIMORE (State) MARYLAND				
24. FUNERAL DIRECTOR'S SIGNATURE FRANK H. NEWELL, INC.		25a. REGISTRATION NUMBER Reisterstown Rd-Waldron Ave., Baltimore, Md. DATE MAY 26 1960								
25b. REGISTRAR'S SIGNATURE Clinton J. Newell										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5393

CERTIFICATE OF DEATH

05451

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		b. COUNTY Baltimore	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1908 Tyler Road		d. STREET ADDRESS 1908 Tyler Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Margaret I. Hardesty	Middle	Last May 4, 1960
4. DATE OF DEATH	Month May	Day 4	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1880
9. AGE (In years lost birthday) 80 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME William P. Powers		
14. MOTHER'S MAIDEN NAME Mary Souberen	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		
16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. M. Himmelman	Address 1908 Tyler Road	
18. CAUSE OF DEATH [Enter only one cause possible for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 5 years 20 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Baltimore	(County) Md.	(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 1-15, 1955, to 5-4, 1960, that (I) (we) last saw the deceased alive on 5-3, 1960, and that death occurred at 3A M., from the causes and on the date stated above.			
22a. SIGNATURE Jack C. Collins		22b. DATE SIGNED 5-6-60	
22c. PHYSICIAN'S NAME (Type) JACK C. COLLINS	M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 2 Kinship Balt. Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 5/7/60	23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer	23d. LOCATION (City, town, or county) Baltimore, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.	ADDRESS Ullrich Funeral Home 2112 Dundalk Ave.	25a. REC'D BY REGISTRAR DATE MAY 11 '60	25b. REGISTRAR'S SIGNATURE C. Clark S. Hause



MARYLAND STATE DEPARTMENT OF HEALTH

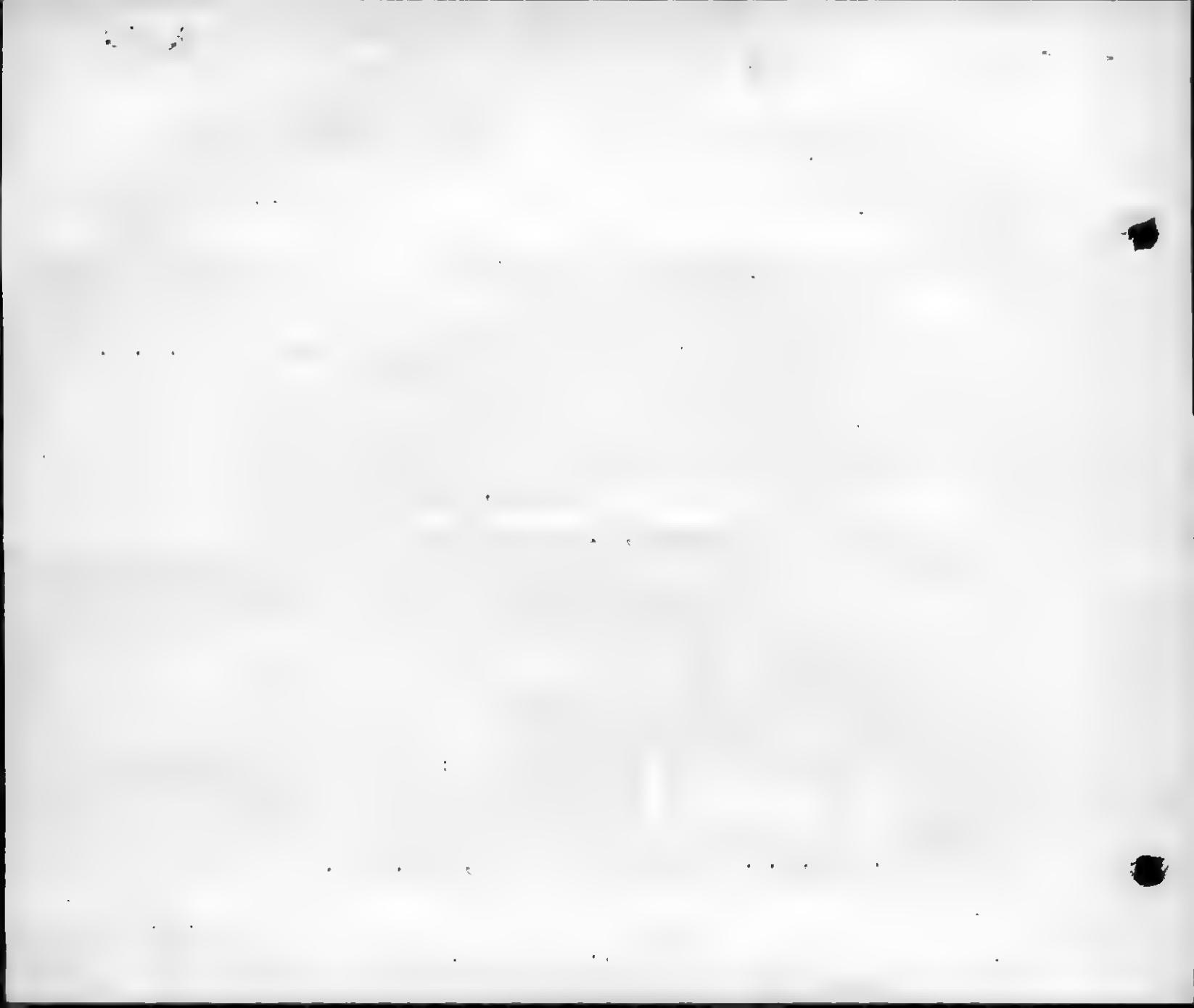
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5475

CERTIFICATE OF DEATH

05452

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN 1b 7 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1433 East Lombard Street, (31)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) RICHARD		First -----	Middle -----	Last HARRIS	4. DATE OF DEATH May	Month May	Day 26	Year 1860
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. AGE (In years lost birthday) 72 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter	11. KIND OF BUSINESS OR INDUSTRY Hotel	12. BIRTHPLACE (State or foreign country) Annapolis, Maryland	13. CITIZEN OF WHAT COUNTRY? U. S. A.
14. FATHER'S NAME West Harris		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown, if yes, give war or date of service) Yes WW I		16. SOCIAL SECURITY NO. 217-01-4573	17. INFORMANT Clinical Records VA Hospital, Baltimore 18, Md. Fort Howard Div.	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Xxx						INTERVAL BETWEEN ONSET AND DEATH 18 MONTHS		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		EPIDERMOID CARCINOMA, SOFT PALATE				5 DAYS		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		PNEUMONIA, RIGHT LOWER LOBE						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (X) (this hospital) attended the deceased from May 19, 1960, to May 26, 1960, that (X) (we) last saw the deceased alive on May 26, 1960, and that death occurred at P. M., from the causes and on the date stated above						22b. DATE SIGNED 5/27/60		
22c. SIGNATURE Thomas R. Hood		M D		ATTENDING PHYS <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>		
22d. ADDRESS VAH, BALTO. 18, MD. FORT HOWARD DIVISION								
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-1-1960		23c. NAME OF CEMETERY OR CREMATORIUM National Cemetery		23d. LOCATION (City, town, or county) Annapolis, Maryland		(State)
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Reese Mortuary, 108 Washington St. Annapolis, Md.		ADDRESS		25a. REC'D. BY REGISTRAR DATE MAY 31 1960		25b. REGISTRAR'S SIGNATURE C. 1978. K. M.		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.

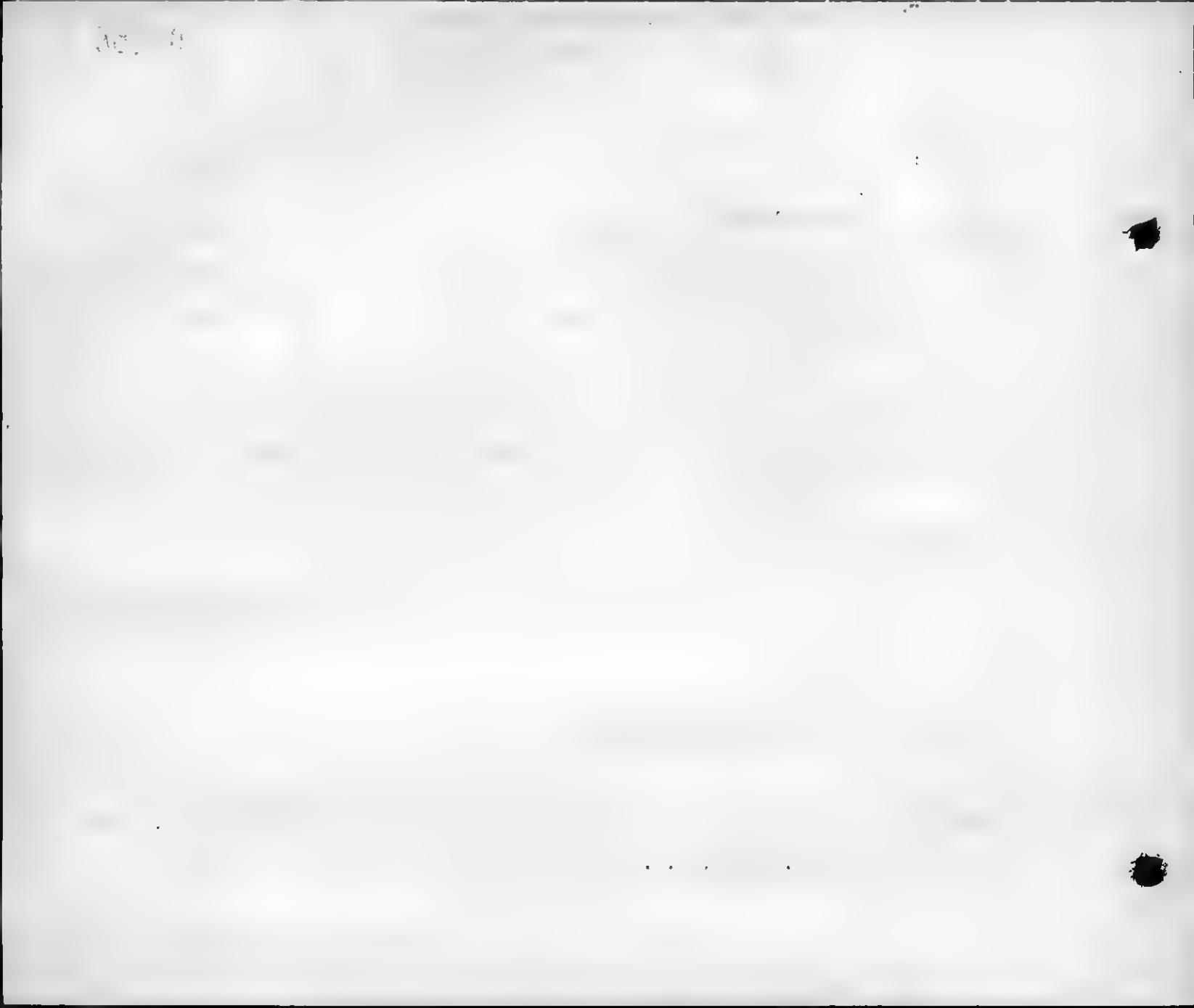
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5476 CERTIFICATE OF DEATH 05453

Reg. Dist. No. ✓

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MD b. COUNTY name				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson		c. LENGTH OF STAY IN lb				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eudowood Sanatorium Towson 4, Maryland		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2225 W Baltimore 23 3117				
3. NAME OF DECEASED (Type or print) Wilhous		Middle	4. DATE OF DEATH Lost May 23 1960			
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH April 13, 1899		9. AGE (In years lost birthday) 61 yrs. IF UNDER 1 YEAR Months Days Hours Min				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Industrial	11. BIRTHPLACE (State or foreign country) Md			
12. CITIZEN OF WHAT COUNTRY US						
13. FATHER'S NAME Charles Helwig		14. MOTHER'S MAIDEN NAME Florence Rutter				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 215-01-5835				
17. INFORMANT Personal History Hospital Records, Eudowood Sanatorium		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 20 days				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Baltimore	(State) MD
21. I certify that I attended the deceased from May 11, 1960, to May 23, 1960, that I last saw the deceased alive on May 23, 1960, and that death occurred at 11:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Milton B. Kress, M.D. Eudowood Sanatorium, Towson 4, Maryland						
PHYSICIAN'S NAME (Type) Milton B. Kress, M.D.		22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 5-15-60 22c. NAME OF CEMETERY OR CREMATORIUM WESTERN				
22d. LOCATION (City, town, or county) BALTIMORE MD						
23. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS 433-35th & Howard St., Towson 4, Maryland		24a. REC'D BY REGISTRAR MAY 3 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kress			
VS A15 (4) 15M 10/57						



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5477

CERTIFICATE OF DEATH

05454

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

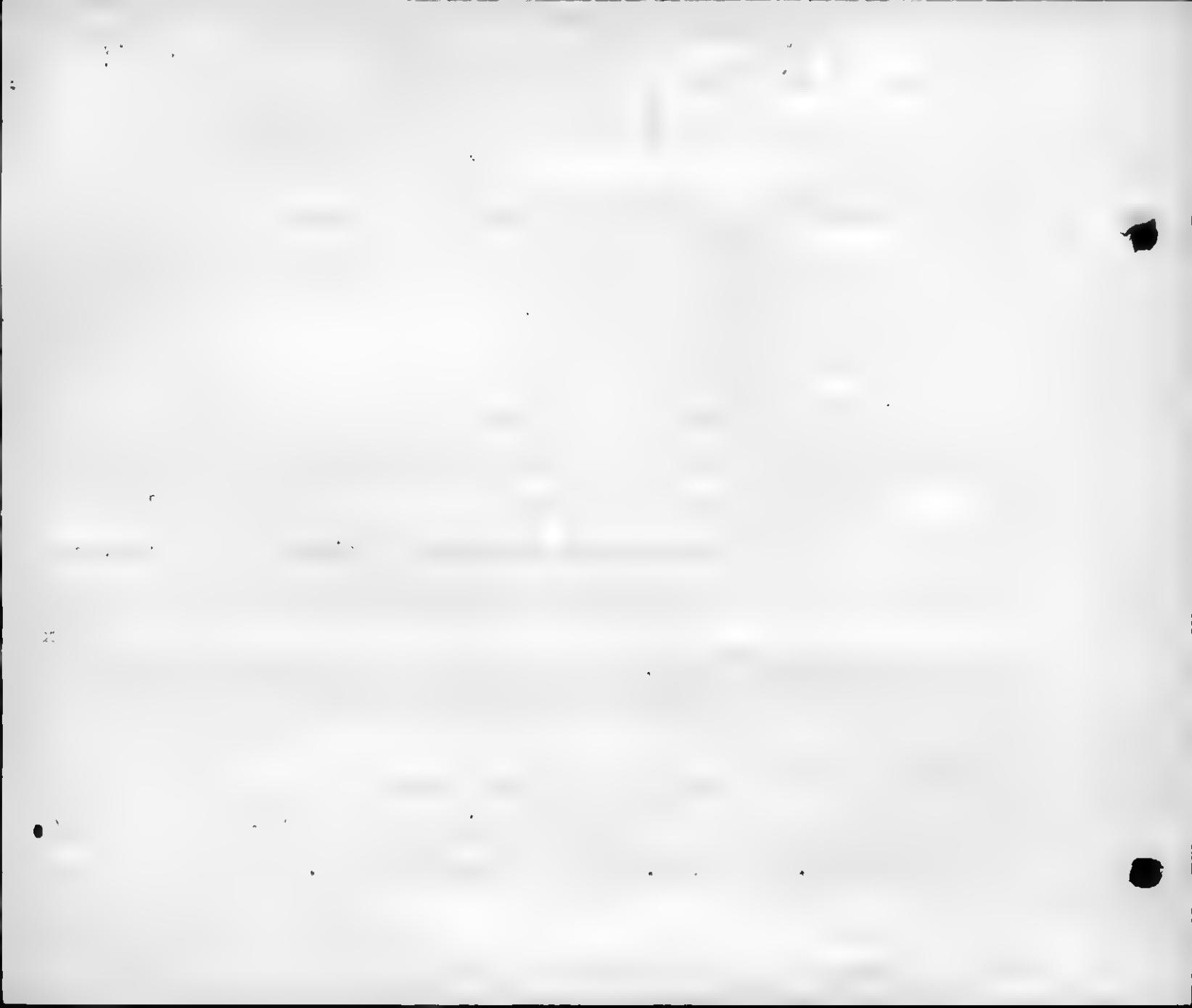
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY <i>Balto.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <i>Md.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodlawn</i>		b. COUNTY <i>Balto.</i>			
c. LENGTH OF STAY IN 1b <i>Woodlawn</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodlawn</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2115 St. Lukes Lane</i>		d. STREET ADDRESS <i>2115 St. Lukes Lane</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>William</i>	Middle <i>E.</i>	Last <i>Henritz</i>		
4. DATE OF DEATH	Month <i>May</i>	Day <i>30</i>	Year <i>1960</i>		
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 23, 1881</i>		
9. AGE (In years lost birthday) <i>79 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. Hours <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>George Henritz</i>	14. MOTHER'S MAIDEN NAME <i>Elizabeth Subock</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Mrs. Elsie L. Henritz - 2115 St. Lukes Lane</i>	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>420.1</i>					
b) <i>Arteriosclerotic cardiovascular disease</i> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>*****</i>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>*****</i> 19 p. m. <i>*****</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>*****</i>	20f. (City or town) <i>*****</i>	(County) <i>*****</i>	(State) <i>*****</i>
21. I certify that I attended the deceased from _____, 19 <i>50</i> , to _____, 19 <i>60</i> , that I last saw the deceased alive on _____, 19 <i>60</i> , and that death occurred at <i>1:10A.M.</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>5101 Gwynn Oak Avenue,</i>	DATE SIGNED <i>5/31/60.</i>
ACTUAL SIGNATURE <i>Millard T. Traband</i>	M.D.				
PHYSICIAN'S NAME (Type) <i>Millard T. Traband, Jr.</i>	Baltimore, 7, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>June 1, 1960</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Olive</i>	22d. LOCATION (City, town, or county) <i>Randallstown</i> (State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John T. Stansbury - 6411 Windsor Mill Rd.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE JUN 1 '60	24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>		



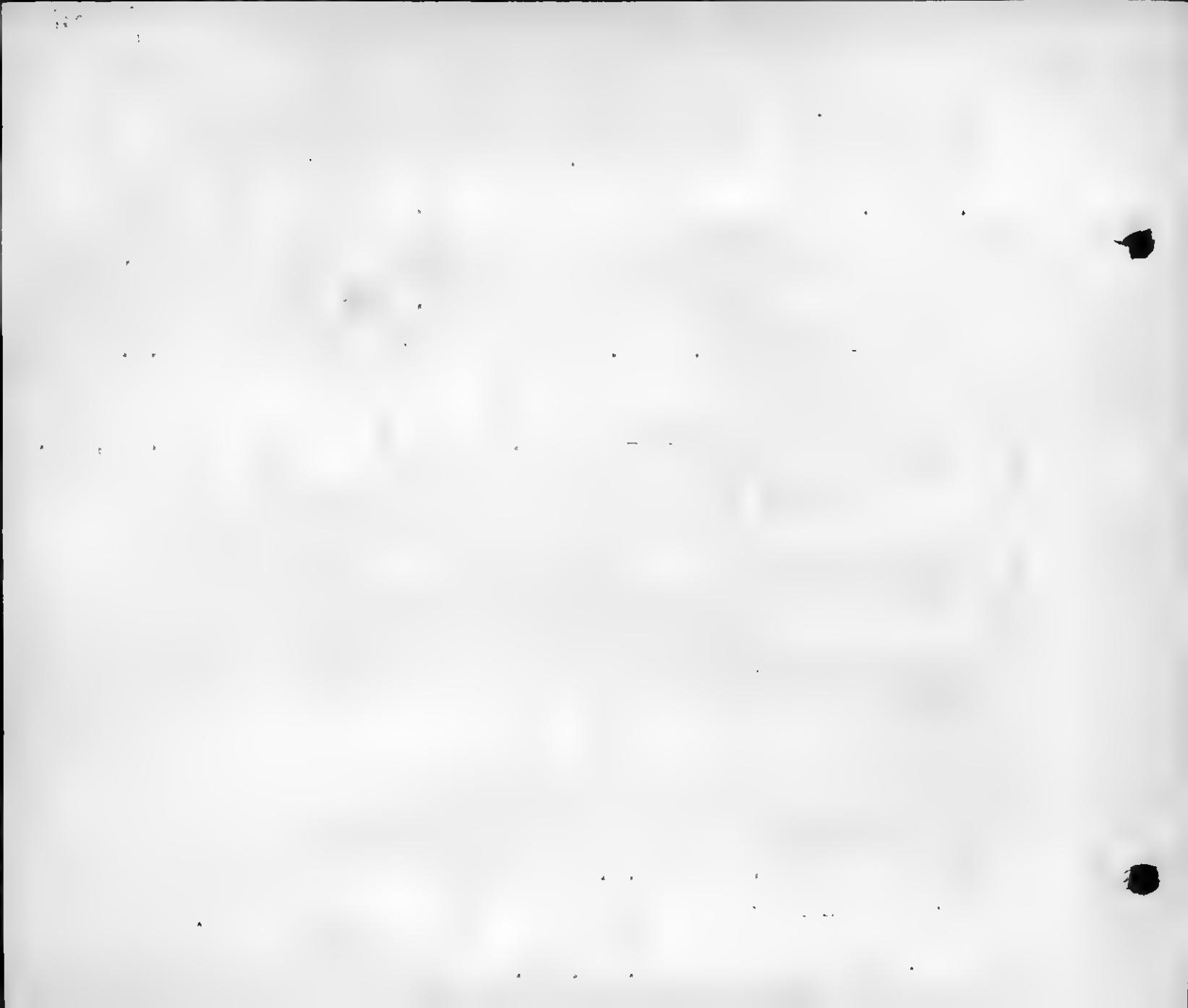
FOR STATE
HEALTH DEPT.

is necessary, please
execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the
Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5478 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05455

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		b. COUNTY Baltimore	
c. LENGTH OF STAY IN lb 19 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Res. 810 E. Street		d. STREET ADDRESS 810 E. Street	
3. NAME OF DECEASED (Type or print) Waldo		First James	Middle Henry
4. DATE OF DEATH May 5, 1960	5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH October 7, 1909	9. AGE (In years at birthday) 50 yrs	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Open Hearth-Office Wrk. Beth. Steel	10b. KIND OF BUSINESS OR INDUSTRY West Virginia
10c. BIRTHPLACE (State or foreign country) West Virginia	11. IF UNDER 1 YEAR Months Days Hours Min.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Henry		14. MOTHER'S MAIDEN NAME Maude Iman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown No		16. SOCIAL SECURITY NO 213-09-0995	17. INFORMANT Mrs. Elizabeth Henry 810 E St. 19, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DUE TO (b) DUE TO (c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Shot Self w. .38 Cal Pistol	
20c. TIME OF INJURY 11:30 a.m.	Month Day, Year 5-5 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Sparrows Pt. - 810 E. St. - Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Melvin B. Davis M.D.</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Melvin B. Davis M.D.	DATE SIGNED 5/5/60		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-7-1960	22c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn	22d. LOCATION (City, town, or county) Eastern Blvd.
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda 7922 Wise Ave. 22. Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE MAY 10 '60	24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be joined by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

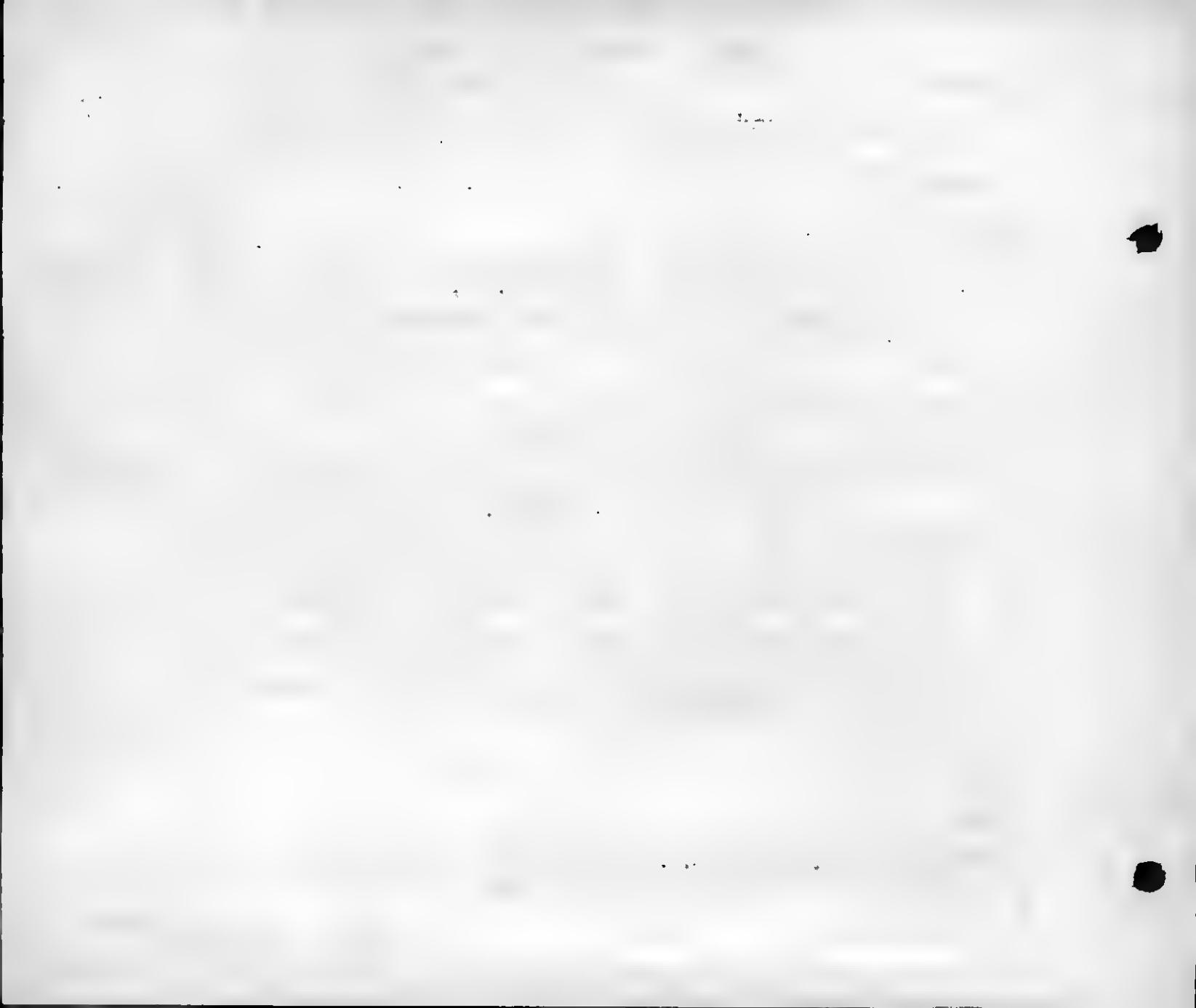
5402

CERTIFICATE OF DEATH

05456

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Relay		c. LENGTH OF STAY IN 1b 23 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Relay Hill Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Relay	
3. NAME OF DECEASED (Type or print) Gladys Hill		Middle First	4. DATE OF DEATH May 16 Day Year 60 19
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13, 1888
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) Indiana		11. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Not known		14. MOTHER'S MAIDEN NAME Not known	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Hospital Record
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 15c DUE TO Carcinoma of the Gall Bladder with generalized metastatic lesions.		INTERVAL BETWEEN ONSET AND DEATH 11/2 MONTHS	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary artery disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woodlawn Cemetery	20f. (City or town) (County) (State) Baltimore
21. I certify that I attended the deceased from April 23, 1960, to May 16, 1960, that I last saw the deceased alive on May 16, 1960, and that death occurred at 5:30 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lewis P. Gundry M.D. DATE SIGNED			
ACTUAL SIGNATURE	PHYSICIAN'S NAME (Type) Lewis P. Gundry, M.D.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/19/60	22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Columbus, May 13, 1960, before Lewis P. Gundry, M.D.		ADDRESS	24a. REC'D BY REGISTRAR MAY 18, 1960
			24b. REGISTRAR'S SIGNATURE Clyde S. Price



1
FOR STATE
HEALTH DEPT.



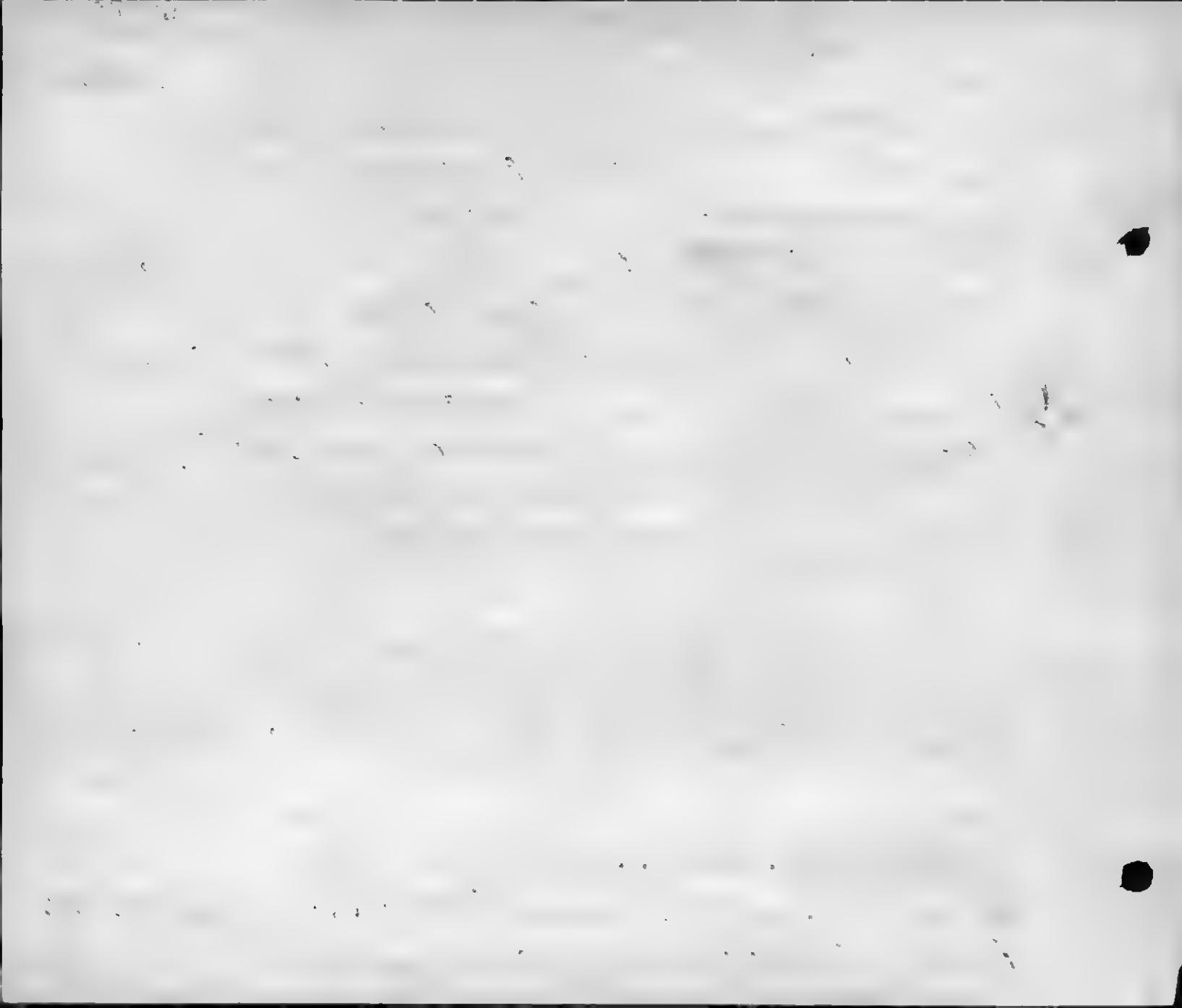
1 delay is necessary,
please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health
or its designated agent, prior to burial, cremation, or removal, and in any case where death occurs within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5479 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

115457

1. PLACE OF DEATH a. COUNTY Baltimore	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md.										
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgemere	b. COUNTY Baltimore										
c. LENGTH OF STAY IN 1b 25 yrs.	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgemere, Md.										
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cottage Aye.	d. STREET ADDRESS 2703 Delk Ct.										
3. NAME OF DECEASED (Type or print) Isiah L. Hill	4. DATE OF DEATH May 29, 1960										
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-23-1932								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper	10b. KIND OF BUSINESS OR INDUSTRY State Truck	11. BIRTHPLACE (State or foreign country) Chester Co., S. C.	9. AGE (In years last birthday) 28 yrs.								
13. FATHER'S NAME Robert Hill	14. MOTHER'S MAIDEN NAME Nancy Lightner	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <input type="checkbox"/> NO	16. SOCIAL SECURITY NO.	17. INFORMANT Robert Hill 2703 Delk Ct.	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemothorax bilaterally and hemopericardium DUE TO Conditions, if any, which gave rise to immediate cause (a), starting the underlying cause last. (b) Stab wounds of chest and abdomen DUE TO (c)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Stab wounds of chest and abdomen	20c. TIME OF INJURY Month, Day, Year Hour XX. May 29, 60 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) Edgemere, Baltimore, Maryland	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.	CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 5/30/60								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-3-60	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Calvary Cem. Anne Arundel Co. Md.	22d. LOCATION (City, town, or country) (State)								
23. FUNERAL DIRECTOR Randolph J. Collick	24a. REC'D BY REGISTRAR JUN 7 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline									



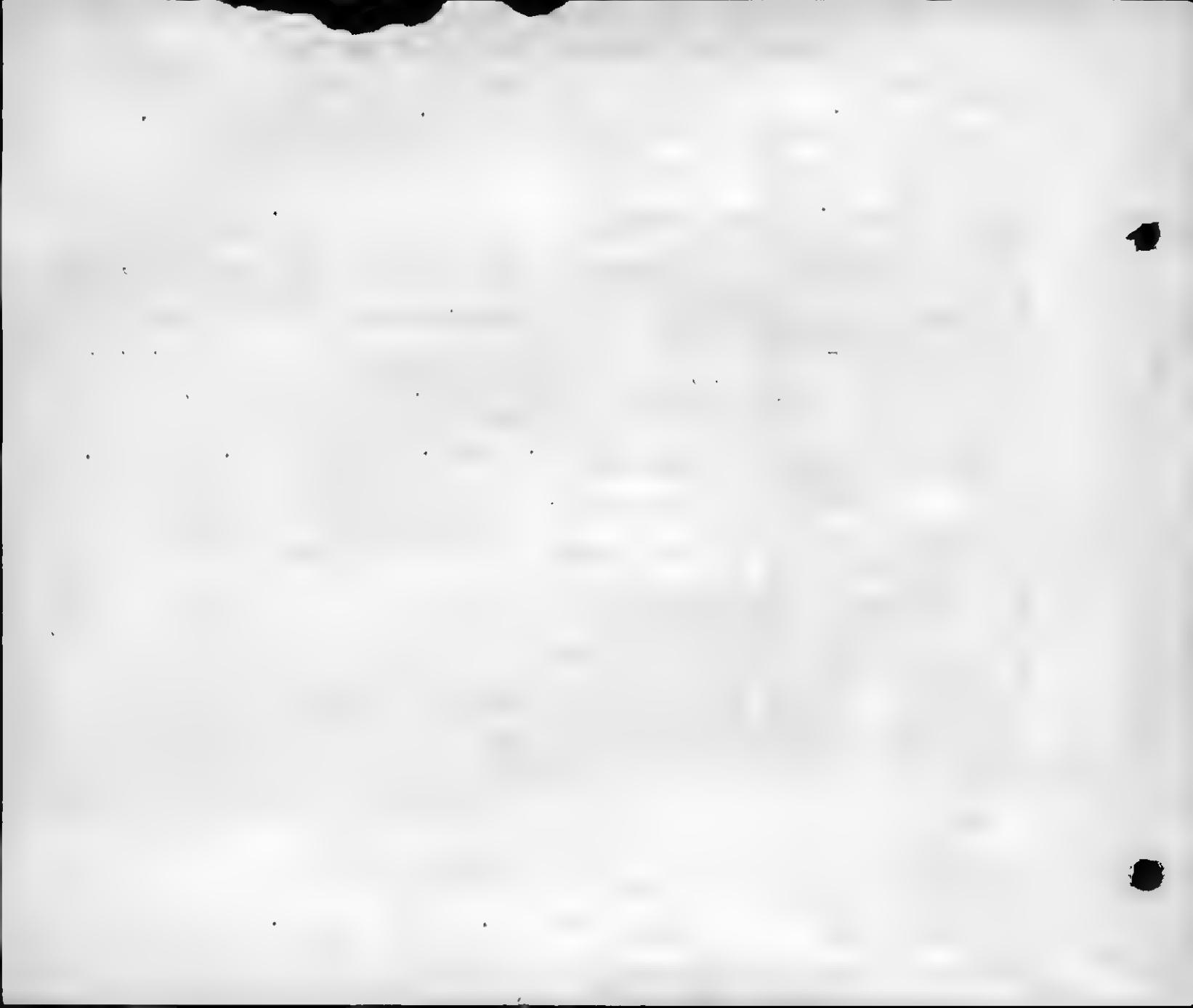
MARYLAND STATE DEPARTMENT OF HEALTH, BALTIMORE, MD.
548 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 16618

1. PLACE OF DEATH a. COUNTY Balto.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. LENGTH OF STAY IN 1b Woodlawn			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wrights Mill Rd.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Woodlawn			
3. NAME OF DECEASED (Type or print) HANS		d. STREET ADDRESS Wrights Mill Rd.			
3. NAME OF DECEASED (Type or print) HANS		4. DATE OF DEATH May 22 1960	Month Day Year		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1887		
9. AGE (in years last birthday) 72		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Arch Designer - self employed		11. BIRTHPLACE (State or foreign country) Germany			
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME - Wilhelm			
14. MOTHER'S MAIDEN NAME Barbara E. Weber		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (To, no, or unknown) no			
16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Harry M. Ashman - 1800 N. Charles St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
Acute Congestive heart failure Cardiovascular disease					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
19					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED May 22, 60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 6/16/60	22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Crem.	22d. LOCATION (City, town, or county) Balto., Md.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Pickens & Sons - Balto. 17		ADDRESS	24a. REC'D BY REGISTRAR JUN 14 '60	24b. REGISTRAR'S SIGNATURE Cuthbert S. Kimes	
			DATE		

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any entry is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

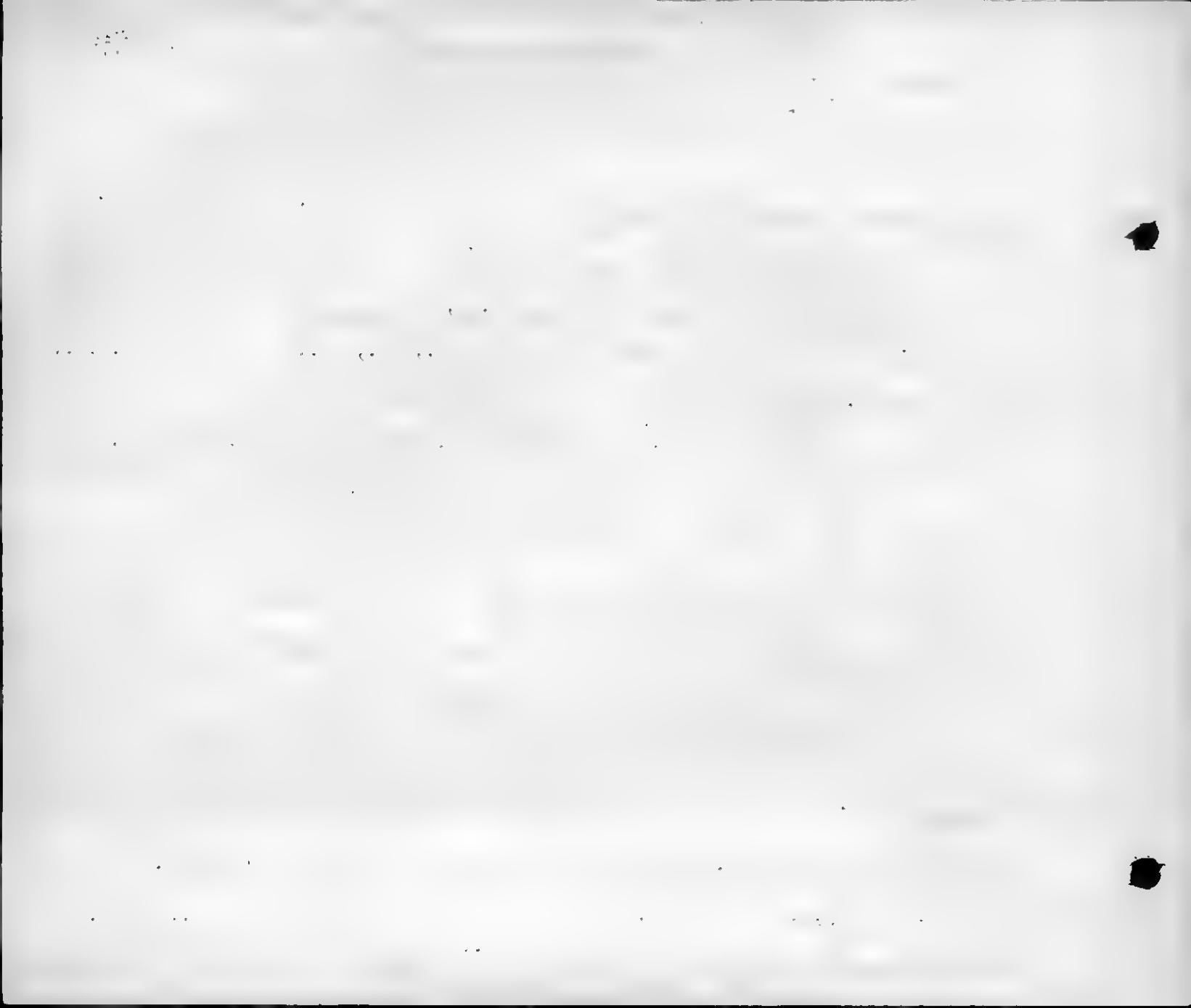
5481

CERTIFICATE OF DEATH

05458

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		5. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
Baltimore		MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Loreley		X Loreley		Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		1 Allender Road,			
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month Day Year
William		J	Holter	May 3	1960
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)
M	W			Mar. 10, 1876	84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Farmer		Owner		Balto., Co., Md.,	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William H. Holter		Mary E. Weis		U.S.A.,	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no		218-14-9402		Margaret C. Holter, Loreley, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebro vascular Acc. 'dent			
122-7 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		A SCVO			
DUE TO					
DUE TO					
DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 : p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on May 3, 1960, and that death occurred at 5 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE William A. Tyson M.D.		Kingsville, Md. 5-3-60			
PHYSICIAN'S NAME (Type) William A. Tyson		Kingsville Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 7, 1960		22c. NAME OF CEMETERY OR CREMATORIUM St. Stephen's	
22d. LOCATION (City, town, or county) Bradshaw		(State) Balto., Md.,			
23. FUNERAL DIRECTOR'S SIGNATURE Howard McCormick Jr.		ADDRESS Abingdon Md.,		24a. REC'D BY REGISTRAR DATE MAY 10 '60	
				24b. REGISTRAR'S SIGNATURE Clinton S. Krause	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be submitted within 24 hours after death. Page 4
may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

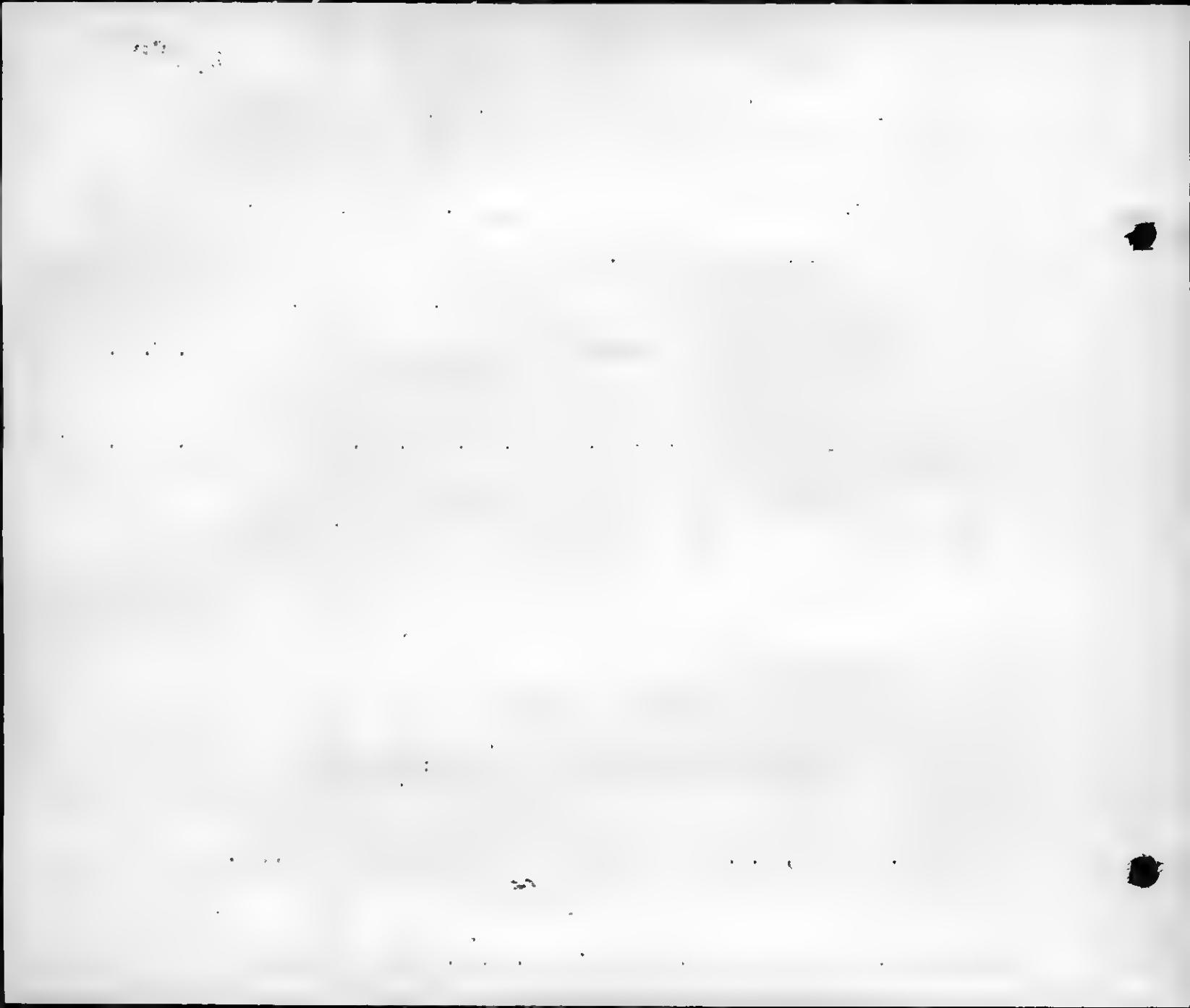
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05459

1. PLACE OF DEATH D. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) D. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 57 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 543 W. Lafayette Avenue		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) WILLIAM		First	Middle O.	Last HOPES	4. DATE OF DEATH May	Month	Day 17	Year 1960
5 SEX Male	6 COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 16, 1889	9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Entertainer		10b. KIND OF BUSINESS OR INDUSTRY Show Business		11. BIRTHPLACE (State or foreign country) Richmond, Virginia		13. FATHER'S NAME William Hopes		
14. MOTHER'S MAIDEN NAME Deanie Smith		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 214-40-1118		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Balto. 18, Md. Ft. Howard		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 155.1 CARCINOMA OF THE AMPULLA OF VATER WITH XXXXX METASTASES TO REGIONAL LYMPH NODES, LIVER AND LUNGS Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) CACHEXIA						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from March 21, 1960, to May 17, 1960, that (1) (we) last saw the deceased alive on May 17, 1960, and that death occurred at p. M., from the causes and on the date stated above.						22b. DATE 5/19/60		
22a. SIGNATURE John D. Talbert, M.D.		22b. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION		22c. SIGNATURE 5/19/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-23-60		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cem.		23d. LOCATION (City, town, or county) Baltimore (State) 28, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips 1808 N. Monroe St. Balto. Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 20 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Phillips		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5483

CERTIFICATE OF DEATH

05460
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Armacost Nursing Home</i>		d. STREET ADDRESS <i>1657 Woodbourne Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Sylvia</i>	First <i>S.</i>	Middle <i>.</i>	Last <i>Howland</i>
4. DATE OF DEATH <i>May 16</i>	Month <i>May</i>	Day <i>16</i>	Year <i>1960</i>
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-14-1905</i>
9. AGE (in years last birthday) <i>54</i>	10. IF UNDER 1 YEAR Months <i>54</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Ohio</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Albert Sedgwick</i>	14. MOTHER'S MAIDEN NAME <i>Charlotte (Unknown last name)</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	16. SOCIAL SECURITY NO. <i>723 189312</i>	INFORMANT <i>DeForest H. Howland</i>	Address <i>same</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>BRAIN TUMOR</i>			
DUE TO <i>d 31</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>6 MONTHS</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>JAN. 11, 1960</i> to <i>MAY 16, 1960</i> that I last saw the deceased alive on <i>MAY 15, 1960</i> , and that death occurred at <i>4 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Arthur Kargin</i>			ADDRESS (Street, city or town, state) <i>1532 Haverwood Rd</i>
DATE SIGNED <i>Arthur Kargin M.D. BALTIMORE-18 MD</i>			
22a. BUR. AL. CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>5/18/60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>MORELAND MEM PARIS BALTIMORE COUNTY</i>	22d. LOCATION (City, town or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5305 Harford Road</i>		24a. REC'D BY REGISTRAR <i>DATE MAY 18 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kargin</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5484

CERTIFICATE OF DEATH

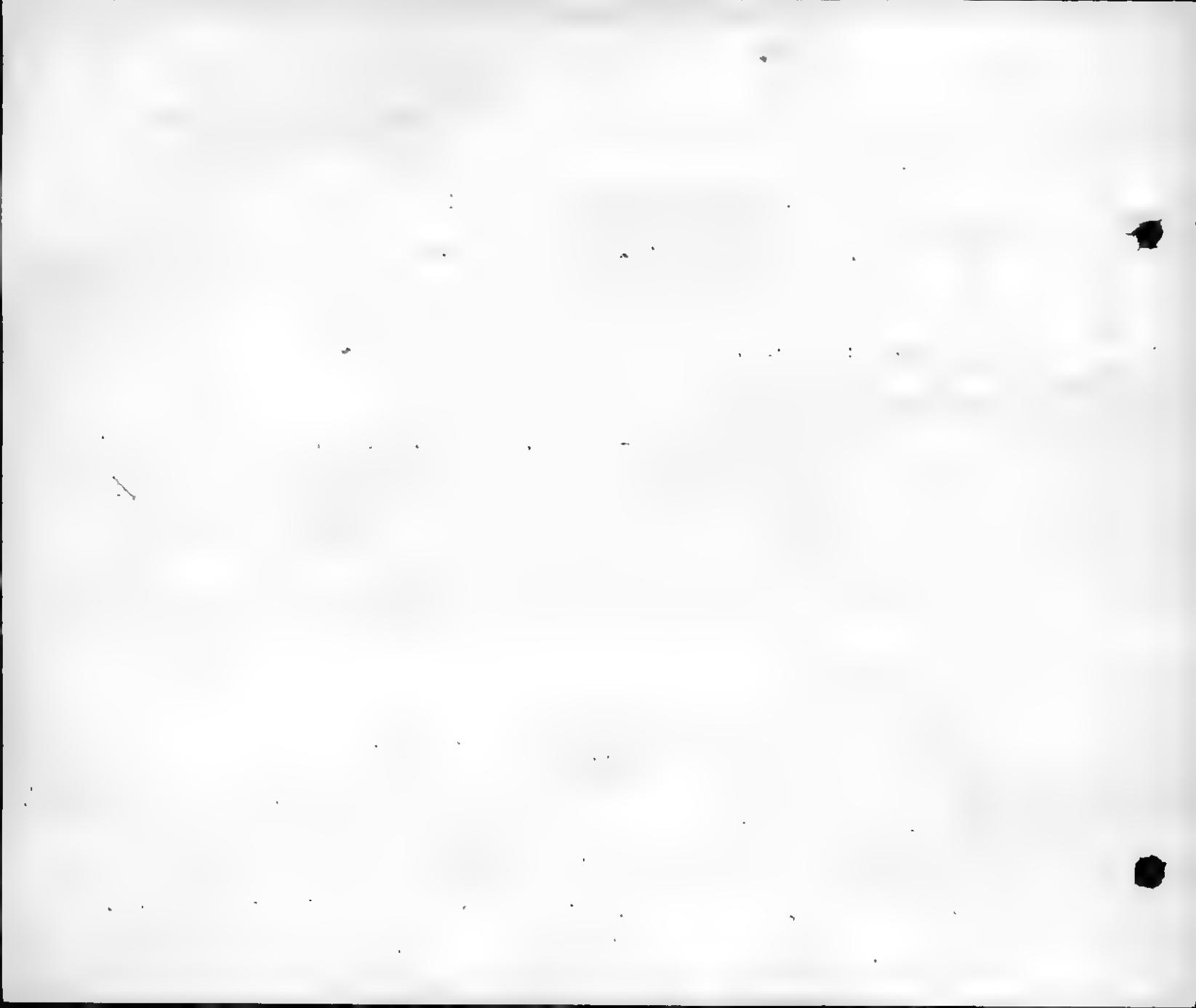
05461

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

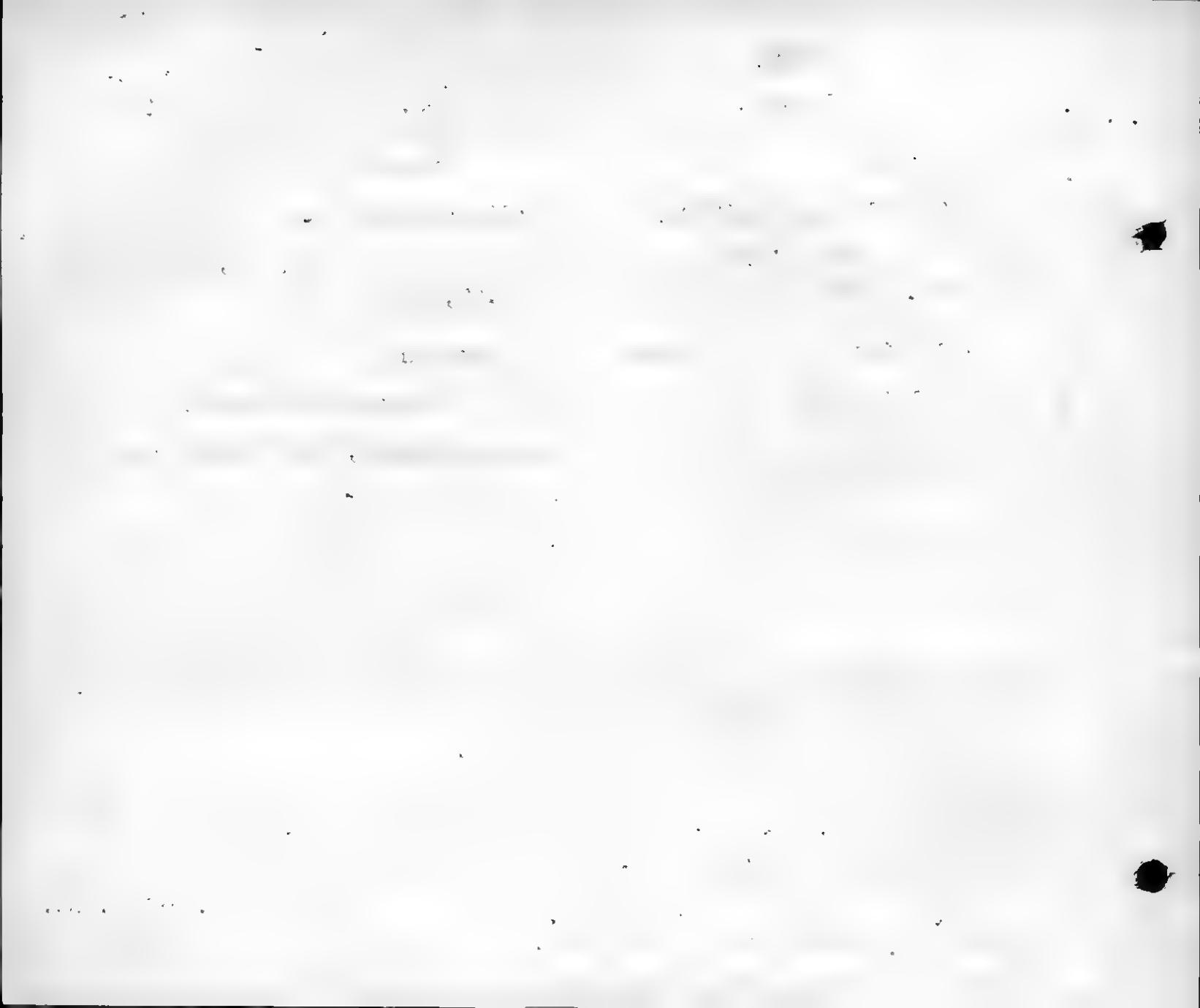
1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b RURAL			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 102 Dumbarton Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mr. James Thomas Hubbard	First James	Middle Thomas	4. DATE OF DEATH Month May Day 31st Year 1960		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1885		
9. AGE (In years last birthday) 74	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Advertising Rep.	11. KIND OF BUSINESS OR INDUSTRY Suffolk, Virginia	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Lepron Hubbard	14. MOTHER'S MAIDEN NAME Lurette ?				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. 216-32-6495 A.	INFORMANT Mrs. Sue E. Hubbard, same	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
aplastic anaemia			INTERVAL BETWEEN ONSET AND DEATH 1 year		
Afteriosclerotic cardio-vascular 2 yrs.					
Dis ease					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy	20d. INJURY OCCURRED While or work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12 Aug , 19 59 , to 31 May , 19 60 that I last saw the deceased alive on 31 May , 19 60 , and that death occurred at 2 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) ADDRESS (Street, city or town, state) Kammer Jr. M.D. 6011 York Rd. Baltimore, Maryland	DATE SIGNED 12 May 1960
ACTUAL SIGNATURE William H. Kammer Jr.	PHYSICIAN'S NAME (Type) William H. Kammer-Jr.				
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 6/3/60	22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery	22d. LOCATION (City, town, or county) Baltimore, Maryland	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14	ADDRESS Leonard J. Ruck 5305 Harford Road #14	24a. REC'D BY REGISTRAR DATE JUN 2 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Krause		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5403 CERTIFICATE OF DEATH

05462
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN 1b 51	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4128 Wilkens Ave (Home)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus	
3. NAME OF DECEASED (Type or print) ANNA C HUDSON		First	Middle
4. DATE OF DEATH May 30, 1960		Month	Day
5. SEX female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Oct. 27, 1866		9. AGE (In years (last birthday) 93) yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
10c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Elizabeth Weckesser Address	
13. FATHER'S NAME Phillip Kohl		14. MOTHER'S MAIDEN NAME Louise Plassil, 4128 Wilkens Ave	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. none	
17. INFORMANT None		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (b) 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (c) DUE TO Longestive Heart Failure.	
19. INTERVAL BETWEEN ONSET AND DEATH		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DATE SIGNED	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1305 Franklin Ave.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/10 , 19 59 , to 5/30 , 19 60 , that I last saw the deceased alive on 5/30 , 19 60 , and that death occurred at 8:00 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Baltimore 27 Md.	
ACTUAL SIGNATURE John L. Lederle, M.D.		DATE SIGNED 5/31/60	
PHYSICIAN'S NAME (Type) IN Frederick Md		22. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 6/3/60		22c. NAME OF CEMETERY OR CREMATORY St Pauls Cemetery	
22d. LOCATION (City, town, or county) Druid Hill Pk. Baltimore Md.		22e. ADDRESS 4107 Wilkens Ave.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		24a. REC'D BY REGISTRAR DATE JUN 2 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

115463

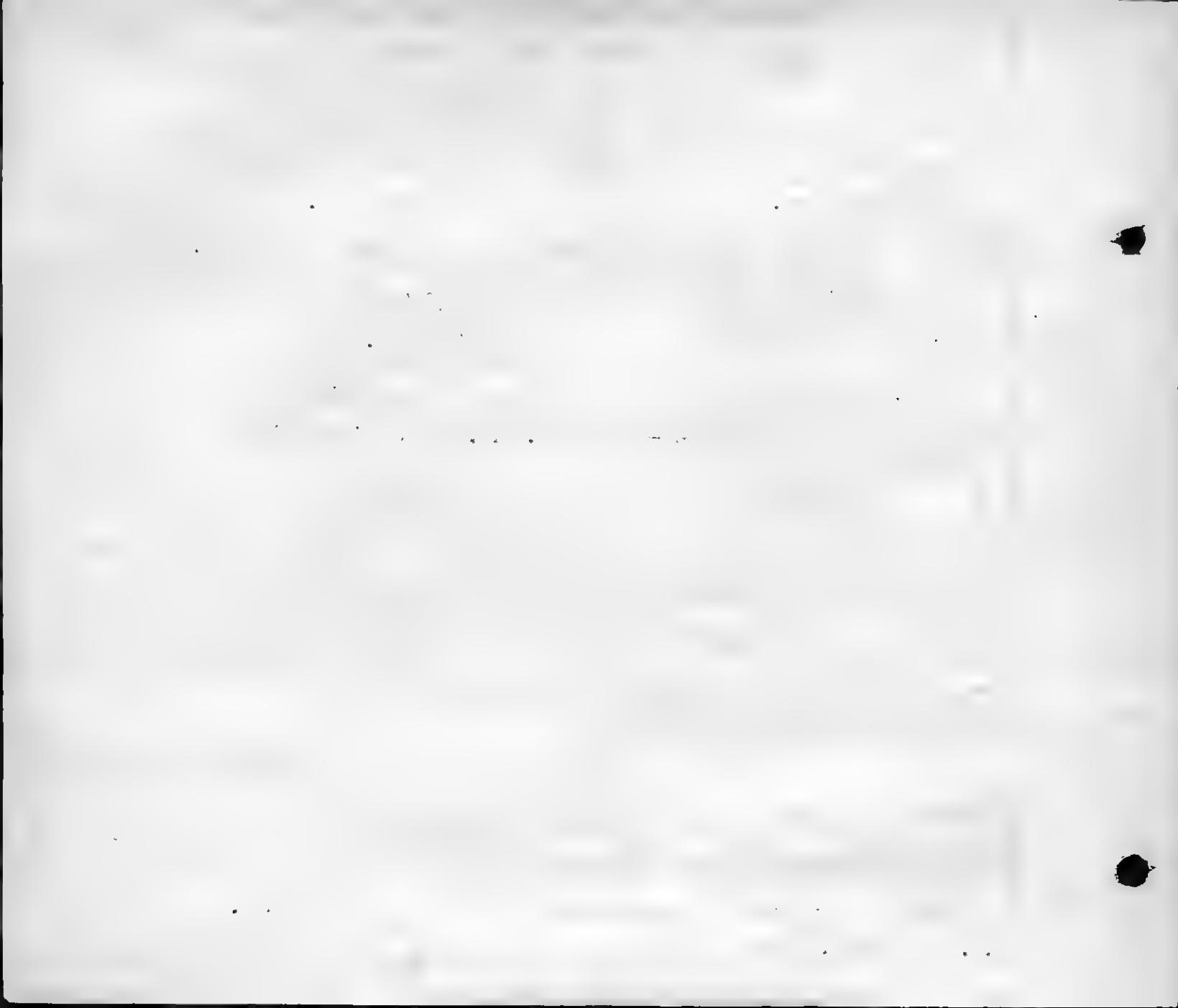
Reg. Dist. No.

5485

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use in the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the register prior to burial, cremation, removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westchester Ave.				d. STREET ADDRESS Westchester Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First LEO	Middle A	HYNES		4. DATE OF DEATH May 25, 1960	Month May	Day 25	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1876		9. AGE (In years lost birthday) 83 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Co. Md		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME John Hynes				14. MOTHER'S MAIDEN NAME Mary Keiffer					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-10-1083		17. INFORMANT Mrs. E.E.Hynes, Ellicott City, Md		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (b), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Central Vascular Accident				INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)							
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)	
21. I certify that I attended the deceased from <u>7-1</u> , 19 <u>59</u> , to <u>5-25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5-25</u> , 19 <u>60</u> , and that death occurred at <u>12th P.M.</u> from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Thomas F. Herbert, M.D.									
PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-28-1960		22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park		22d. LOCATION (City, town, or county) Baltimore, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE MAY 21, 1960 John S. Evans			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05464

5486

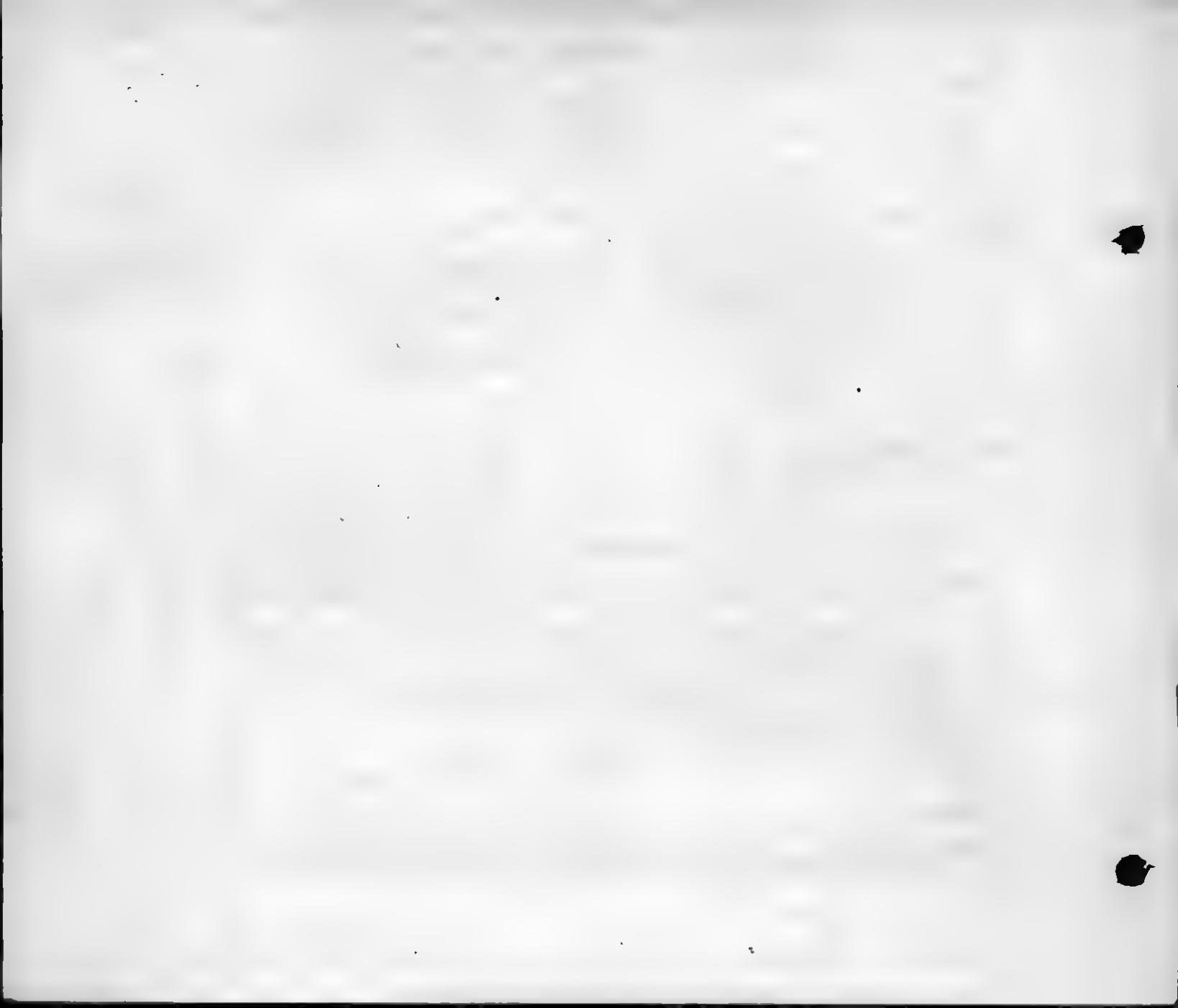
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 55		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 504 Fairway Court		d. STREET ADDRESS 504 Fairway Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Teresa H. Irwin		First	Middle	Last	4. DATE OF DEATH May 3, 1960	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1917		9. AGE (In years lost birthday) 43	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John W. Cutchin			14. MOTHER'S MAIDEN NAME Annie Luter					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 217-20-9207		17. INFORMANT Mrs. Donald Spencer-504 Fairway Ct.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			Carcinoma of liver & Pleura metastatic from abdomen Primary site undetermined			INTERVAL BETWEEN ONSET AND DEATH 6 Mos
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>May 5</u> , 19 <u>60</u> to <u>May 3</u> , 19 <u>60</u> that I last saw the deceased alive on <u>May 2</u> , 19 <u>60</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.					ADDRESS (Street, city or town, state)			DATE SIGNED
ACTUAL SIGNATURE Donald W. Mintzer		M.D. 300 GREENE AVENUE MAY 3/60						
PHYSICIAN'S NAME (Type) DONALD W. MINTZER		Baltimore 14 Md						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 6, 1960		22c. NAME OF CEMETERY OR CREMATORIAL Blandford Cemetery		22d. LOCATION (City, town, or county) Petersburg		(State) Va.
23. FUNERAL DIRECTOR'S SIGNATURE Jm Cook-Towson, Inc.		ADDRESS 1050 York Rd. Towson		24a. REC'D BY REGISTRAR MAY 4 '60		24b. REGISTRAR'S SIGNATURE Clyde S. Kline		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

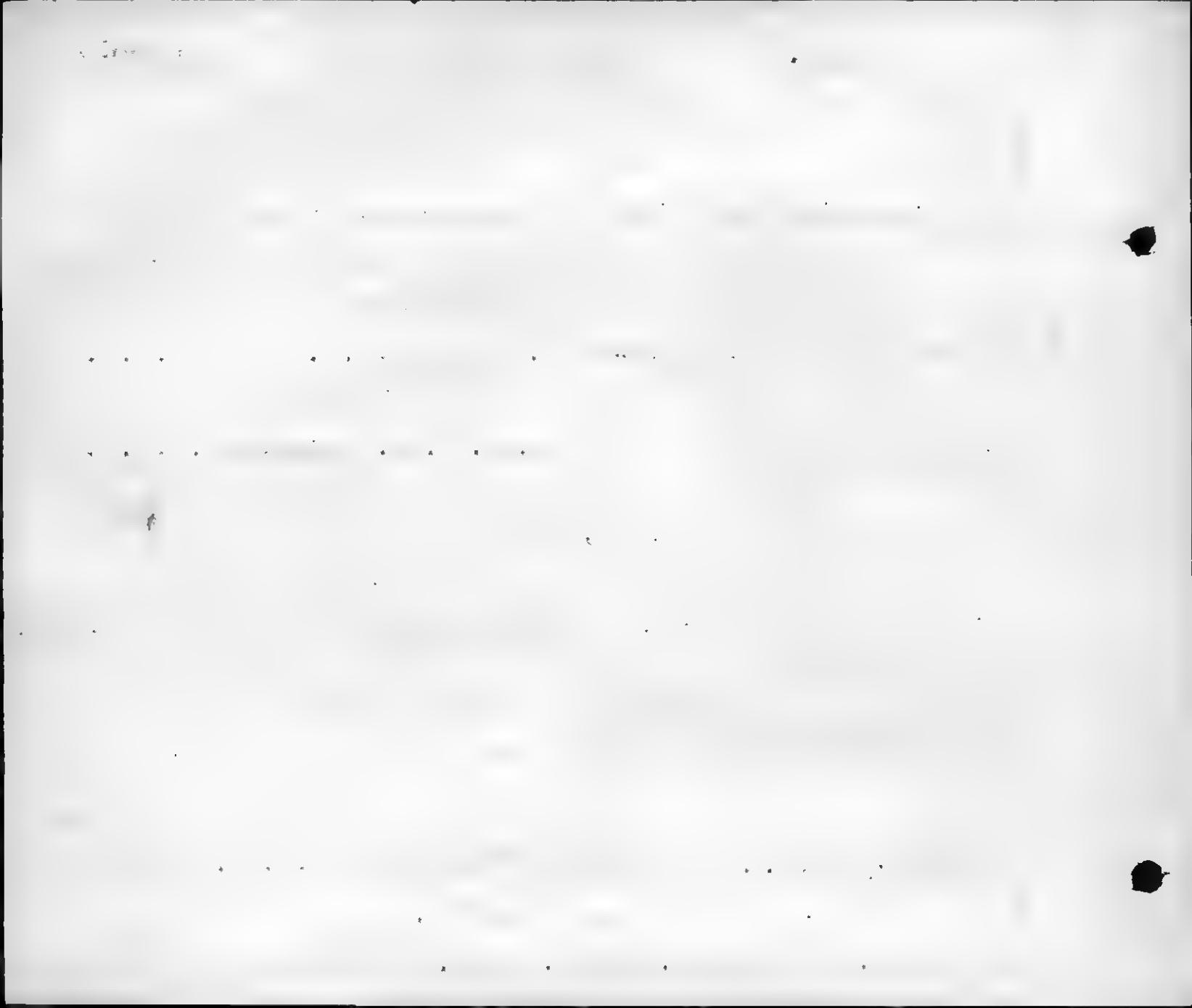
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5487

CERTIFICATE OF DEATH

05465

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 3000 Pressman Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LONNIE		First	Middle --	Last JEFFERSON	4. DATE OF DEATH May	Month 29	Day 19	Year 60	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 20, 1893	9. AGE (In years last birthday) 66 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours	13. IF Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co.		11. BIRTHPLACE (State or foreign country) Lynchburg, S. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME JOHN JEFFERSON		14. MOTHER'S MAIDEN NAME CARRIE MC DONALD							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Clin. Rec. Vet. Adm. Hospital, Balto. 18, Md. Ft. Howard		Address Division			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		EDEMA OF THE LUNGS							
522 XDXSK Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		DEHYDRATION, SEVERE							
4. INTERVAL BETWEEN ONSET AND DEATH 24 HOURS		4 DAYS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Benign Prostatic Hypertrophy. Small Carcinoma of cecum									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that (X) (this hospital) attended the deceased from May 28 1960 to May 29 1960, that (X) (we) last saw the deceased alive on May 29 1960, and that death occurred at 9:30 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Thomas R. Hood THOMAS R. HOOD, M.D.		22b. DATE 5/31/60							
22c. PHYSICIAN'S NAME THOMAS R. HOOD, M.D.		22d. ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/2/60		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cem.		23d. LOCATION (City, town, or county) Baltimore 28, Maryland		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, 1808 N. Monroe St., Balto, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 6 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Krause			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5488

05466

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

BALTIMORE

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

COCKEYSVILLE

c. LENGTH OF STAY IN 1b

6 MONTHS

d. NAME OF HOSPITAL (If not in hospital, give street address)

OR INSTITUTION

MASONIC HOME

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)

a. STATE

MARYLAND

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

BALTIMORE

30014

3. NAME OF DECEASED
(Type or print)First
NELSON

Middle

JOHNSON

Last

DEATH
MAYMonth
MAYDay
31Year
1960

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

2-29-1876

9. AGE (In years
from birth)
84

yrs.

10. IF UNDER 1 YEAR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SALESMAN

10b. KIND OF BUSINESS OR INDUSTRY

HARDWARE

11. BIRTHPLACE (State or foreign country)

SWEDEN

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

NOT KNOWN

14. MOTHER'S MAIDEN NAME

NOT KNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

215-32-2793

17. INFORMANT

Frank L. Smith Jr. - Cockeysville, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

45201

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Arterio Sclerotic Cardio

Vascular Disease

INTERVAL BETWEEN
ONSET AND DEATH

2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.20d. INJURY OCCURRED
While
at work Not while
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 11-30 1957 to 5-30 1960, that (I) (we) last
saw the deceased alive on 5-30 1960 and that death occurred at 20R, from the causes and on the date stated above.

22a. SIGNATURE

Walter T. Kees

M.D.

ATTENDING
PHYS.MED
DIRECTOR STAFF
PHYS 22b. DATE
SIGNED
5/31/6022c. PHYSICIAN'S
NAME (Type)

WALTER T. KEEPS

22d. ADDRESS

COCKEYSVILLE, M.D.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

6-2-60

23c. NAME OF CEMETERY OR CREMATORI

Baltimore Cemetery

23d. LOCATION (City, town, or county)

Baltimore

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Wm. Cook, Inc., 1217 St. Paul Street, Zone 2

25a. REC'D BY REGISTRAR

DATE JUN 1 '60

25b. REGISTRAR'S SIGNATURE

C. L. S. Kees



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5489

CERTIFICATE OF DEATH

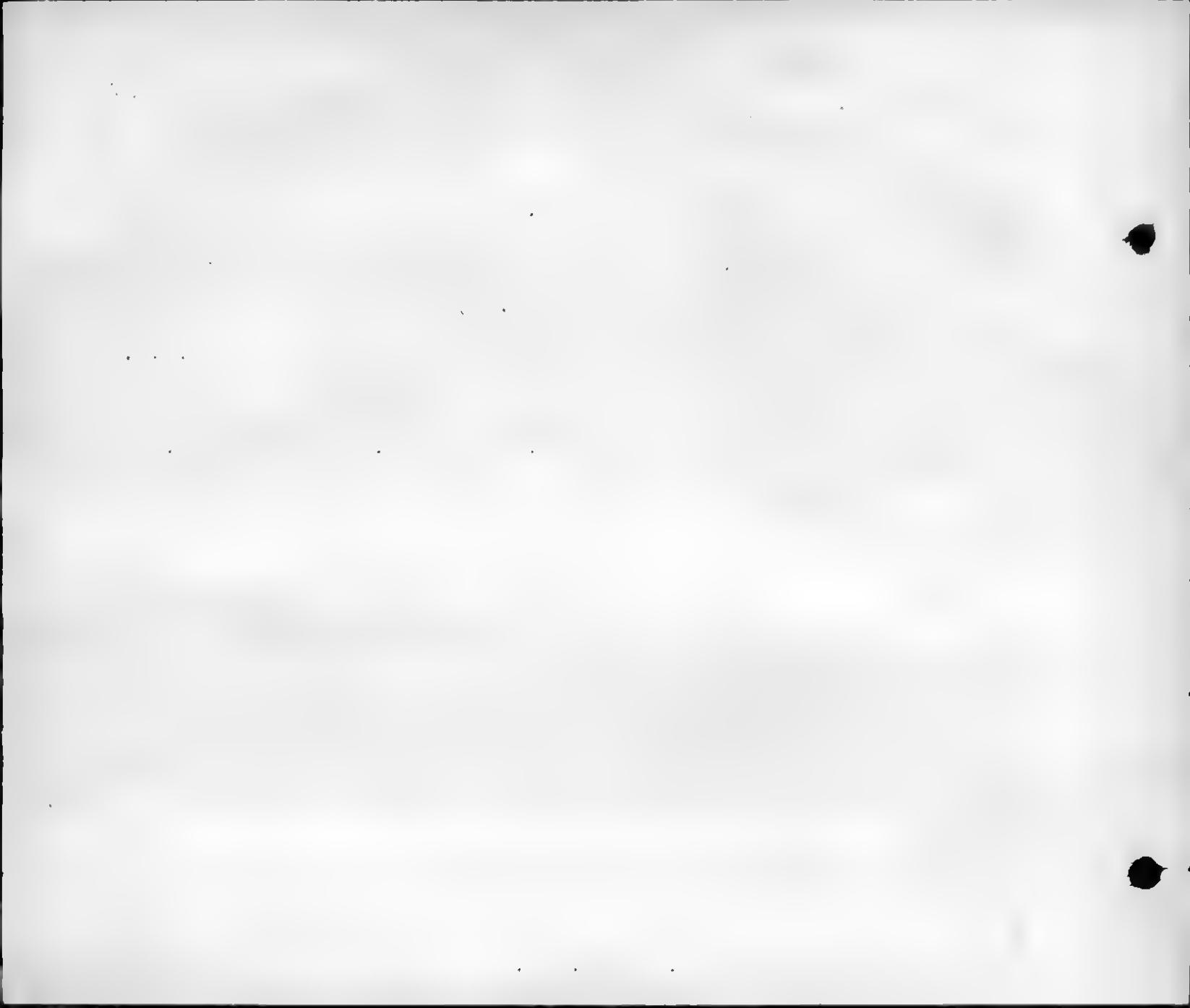
05467

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b ONE YEAR	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RIDGEWAY MANOR 5743 EDMONDSON AVE.		e. STREET ADDRESS 211 NORTH LUZERNE AVENUE	
3. NAME OF DECEASED (Type or print) SOPHIE H. JOHNSON		First Middle Last	4. DATE OF DEATH MAY 28, 1960 Month Day Year 19
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Jan. 2, 1877
8. AGE (In years last birthday) 83		9. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) WISCONSIN		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. RAYMOND S. JOHNSON 211 N. LUZERNE AV		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec. 19, 1958, to May 28, 1960, that I last saw the deceased alive on May 24, 1960, and that death occurred at 4:30 A.M., from the causes and on the date stated above ACTUAL SIGNATURE J. Nelson McWayne M.D. ADDRESS (Street, city or town, state) J. NELSON McWAYNE, MD 6014 Edmondson Ave. DATE SIGNED 5/29/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 31, 1960	
22c. NAME OF CEMETERY OR CREMATORIUM PARKWOOD CEMETERY		22d. LOCATION (City, town, or county) BALTIMORE MARYLAND (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTO. MD.		24a. REC'D BY REGISTRAR DATE MAY 31, 1960	
		24b. REGISTRAR'S SIGNATURE Clarence S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5490

05468

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 11 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		d. STREET ADDRESS 1961 WEST LEXINGTON STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CLARENCE		First — Middle		4. DATE OF DEATH MAY 9 1960		Month Day Year	
5. SEX MALE		6. COLOR OR RACE COLORED Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 1-3-12		9. AGE (in years last birthday) 48 yrs	
10a. US/JAI OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY TRANSPORTATION CO.		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MIKE JONES				14. MOTHER'S MAIDEN NAME MINNIE WILLIAMS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES (if yes, give war or dates of service) WW-11				16. SOCIAL SECURITY NO 705-09-0160 17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GLIOMA OF THE BRAIN, LEFT TEMPORAL LOBE 193.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) EDEMA OF LUNGS (c) BRONCHOPNEUMONIA, RIGHT LUNG				Address INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 Nat white p. m. <input type="checkbox"/> at work <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 28 1960 to May 9 1960 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 9 1960 and that death occurred 6:50 pm from the causes and on the date stated above.				22b. DATE SIGNED 5-10-60			
22a. SIGNATURE John D. Talbert, M.D.				22b. DATE SIGNED 5-10-60			
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22d. ADDRESS VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION			
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-13-1960		23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL		23d. LOCATION (City town or county) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S Phillips Funeral Home				ADDRESS 1001-1011 N Monroe St. Baltimore 17 MD		25a. REC'D BY REGISTRAR MAY 12 '60	
						25b. REGISTRAR'S SIGNATURE Charles S. Tissue	



Item 18 Film 262 5-13 MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

548 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DIVISION OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, end 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY

BALTIMORE

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

615 Main Street

3. NAME OF
DECEASED
(Type or print)

GWENDOLYN

First

Middle

5. SEX

Female

Colored

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Child

JONES

Lost

615 Main Street

4. DATE
OF
DEATH

Month

May 5

Day

19 60

Year

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

14. MOTHER'S MAIDEN NAME

Dorothy Mae Holloway

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

292.6

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

PENDING Acute Bronchopneumonia

INTERVAL BETWEEN
ONSET AND DEATH

Sickle cell disease

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)

19. WAS AUTOPSY
PERFORMED?
YES NO 20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 1920d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

BALTIMORE, Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER DATE SIGNED
5/5/60

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial22b. DATE THEREOF
5/9/6022c. NAME OF CEMETERY OR CREMATORIUM
Mt. Calvary Cem.22d. LOCATION (City, town, or county)
Baltimore 25 Maryland

(State)

23. FUNERAL DIRECTOR

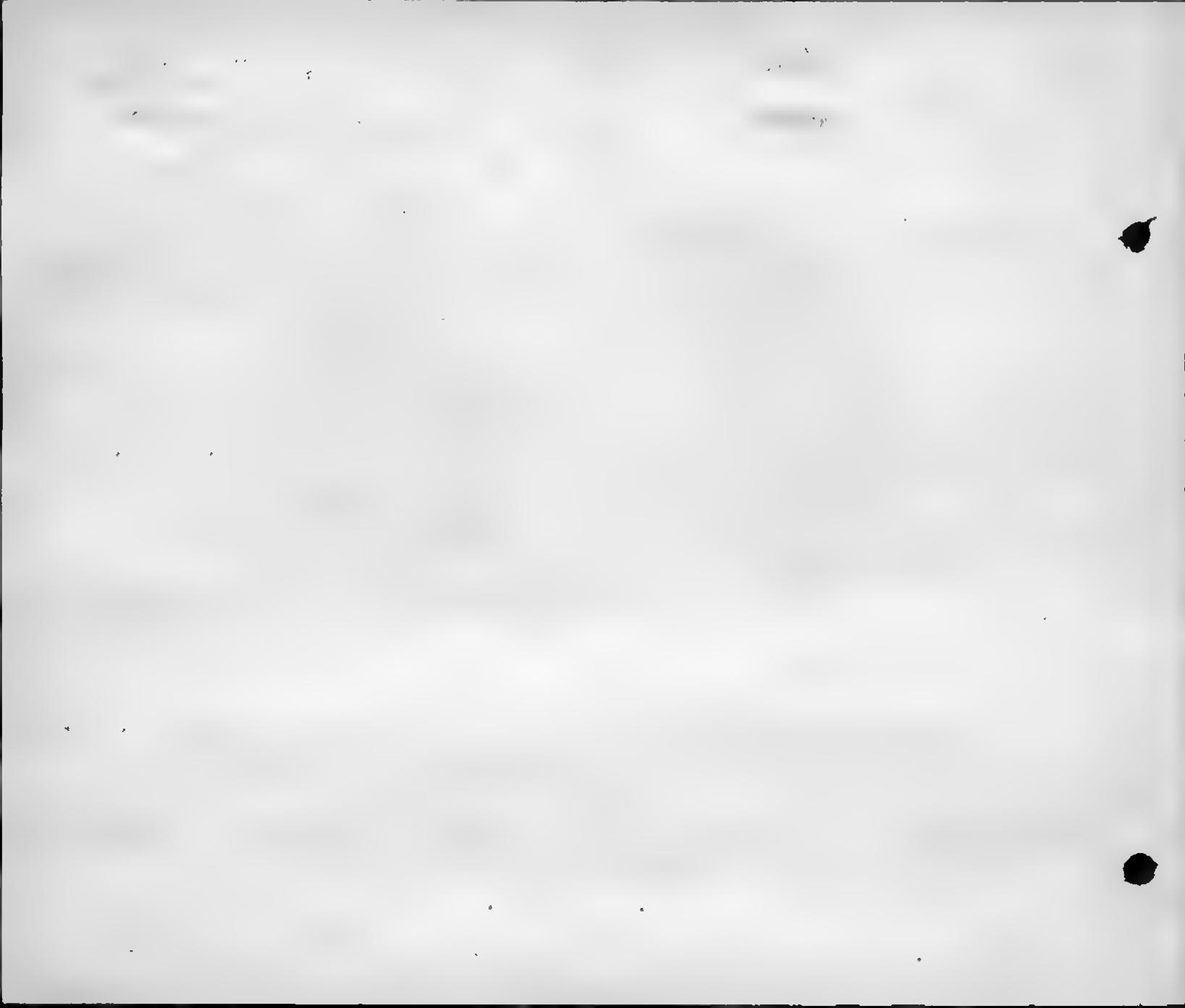
ADDRESS

Wm. A. Jackson Funeral Home 916 Penna. Ave.

24a. REC'D BY REGISTRAR

DATE MAY 9 '60

24b. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5492

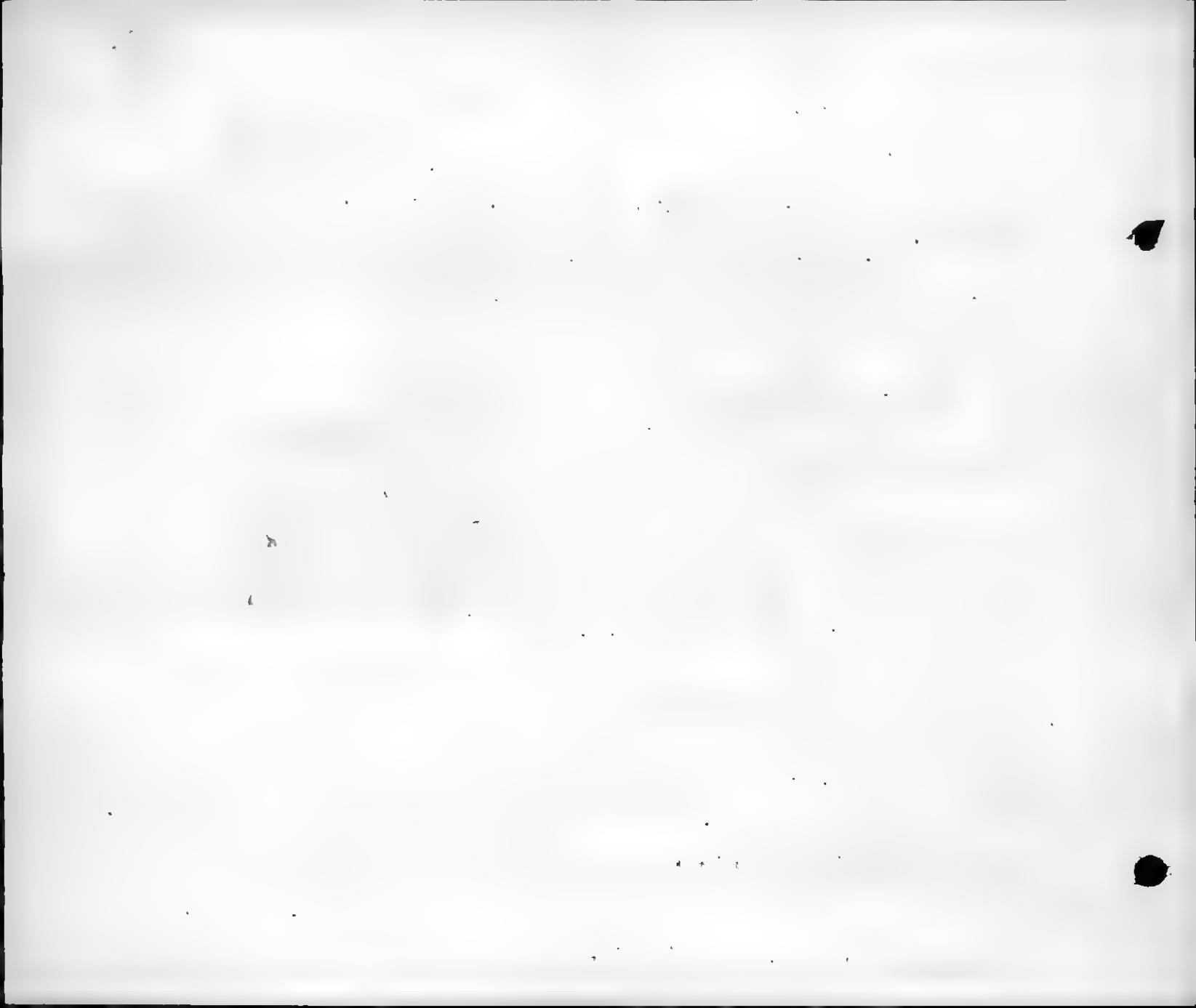
CERTIFICATE OF DEATH

054210

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. LENGTH OF STAY IN lb Parkville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8535 Quentin Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dickran		First Dickran	Middle Kachadourian
4. DATE OF DEATH May 25, 1960		Month May	Day 25
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Jan. 1, 1882		9. AGE (In years last birthday) 78	10. IF UNDER 1 YEAR Months 0 Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Rug business	11. BIRTHPLACE (State or foreign country) Turkey
13. FATHER'S NAME Nushan Kachadourian		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 217329725A	17. INFORMANT Armenoohi Kachadourian
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) H20/1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		Coronary artery occlusion Angina pectoris	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coccioma of lungs		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/15/60 to 5/25/60 that I last saw the deceased alive on 5/15/60 and that death occurred at 89 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Gordon Grau, M.D. M.D. 8523 Rock River Blvd 5/25/60	
ACTUAL SIGNATURE Gordon Grau		DATE SIGNED 5/25/60	
PHYSICIAN'S NAME (Type) Gordon Grau, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-28-60	22c. NAME OF CEMETERY OR CREMATORIAL Moreland Mem. Park
22d. LOCATION (City, town, or county) Baltimore, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Rd.		24a. REC'D BY REGISTRAR DATE MAY 31 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5493

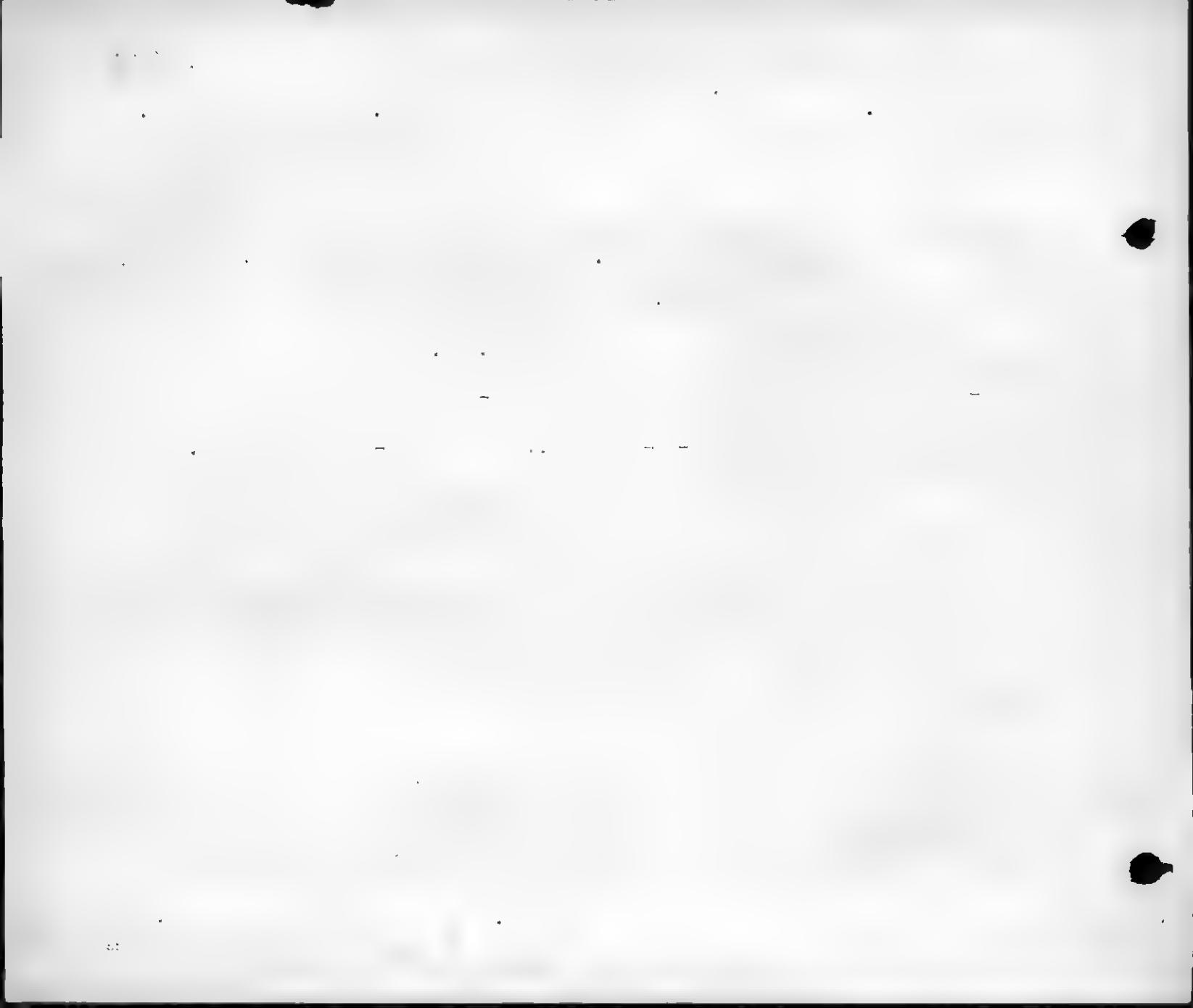
Item 1 11-12-64 0-0-0-0

CERTIFICATE OF DEATH

05471

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville Manor		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville - Manor		d. STREET ADDRESS 5902 Cecil Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5902 Cecil Avenue (At home)				d. STREET ADDRESS 5902 Cecil Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CHARLOTTE	Middle M.	Last KANE	4. DATE OF DEATH May 25, 1960	Month May	Day 25	Year 1960
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED	8. DATE OF BIRTH July 1901	9. AGE (In years last birthday) 58	10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Cleaning		10b. KIND OF BUSINESS OR INDUSTRY City School Board		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME —		14. MOTHER'S MAIDEN NAME Dailey					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO 215-07-0335		17. INFORMANT Mr. Lloyd Kane - 5902 Cecil Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 425- Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b)		Myocardial failure		INTERVAL BETWEEN ONSET AND DEATH , hrs.	
		DUE TO (c)		Cardio-vascular disease		5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Pikesville	(County) (State) Md.
21 I certify that (I) (this hospital) attended the deceased from April 25, 1960, to May 25, 1960, that (I) (we) last saw the deceased alive on May 25, 1960, and that death occurred at 9a M, from the causes and on the date stated above.							
22a. SIGNATURE Homer L. Todd		M. D. <input type="checkbox"/> ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Homer L. Todd		22d. ADDRESS 2108 8th Street					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/28/60		23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge Cem.		23d. LOCATION (City, town, or county) Pikesville, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Licker & Sons - Bistro		ADDRESS Md.		25a. REC'D BY REGISTRAR DATE MAY 31 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN:
Signed by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR CLINIC: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use in the burial permit. Then please remove carbon paper. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

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Released by Coroner

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

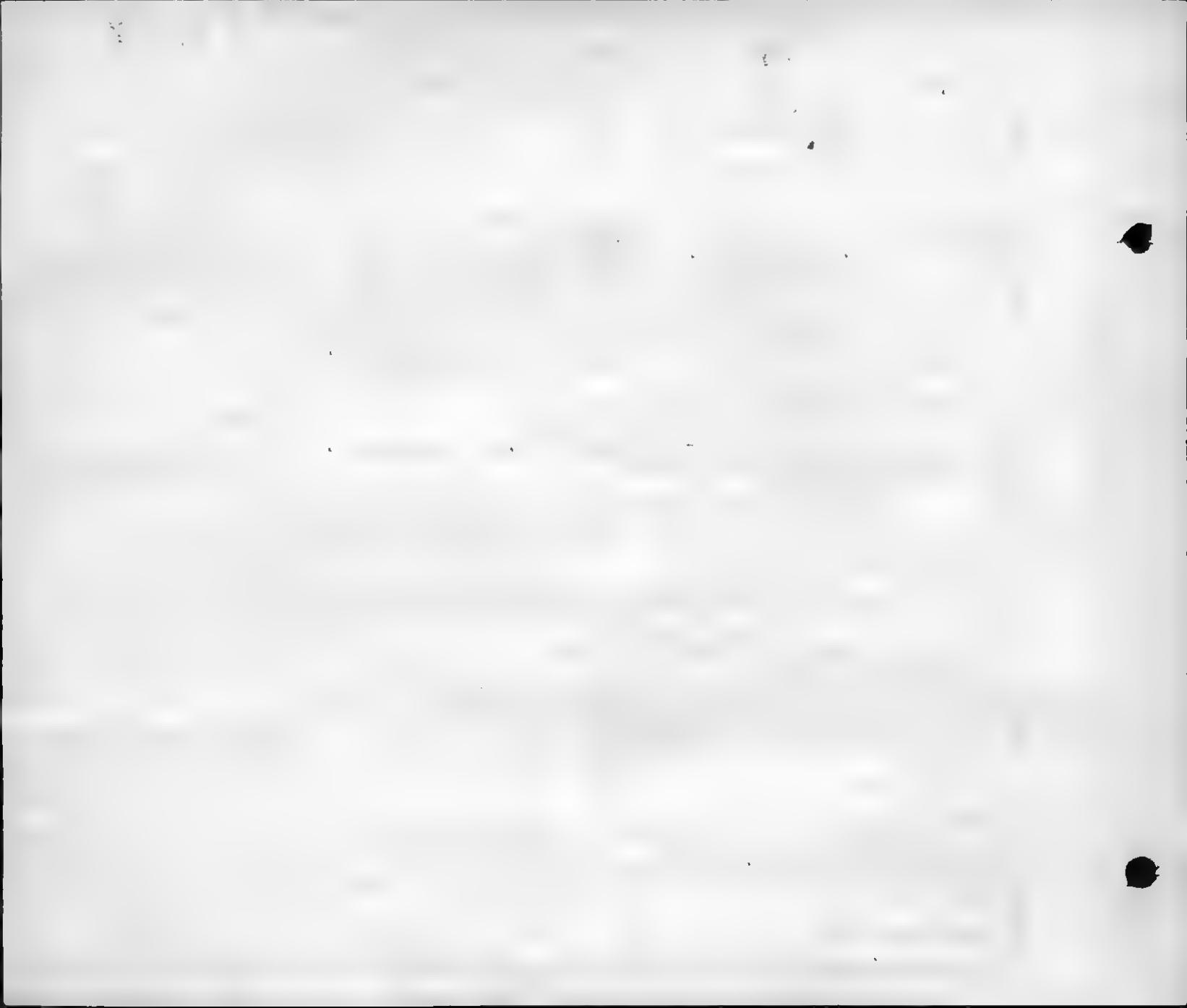
5494

CERTIFICATE OF DEATH

05472

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE	
Baltimore MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7900 Aiken Avenue		d. STREET ADDRESS 17900 Aiken Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mr. John C. Keister	Middle	Last
4. DATE OF DEATH	Month May	Day 31st	Year 1960
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1889
male	white		9. AGE (In years last birthday) 70 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Balto City Employee		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Manor, Penna.	
12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME Ulysses Keister		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-40-4647	
17. INFORMANT Mrs. Catherine R. Keister		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH —	
490.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO Coronary Thrombosis	
(b) Cardio-Vascular Hypertension Disease		7 years	
(c) Arteriosclerosis		7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. g. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1953, to May 31, 1960, that I last saw the deceased alive on Feb 12, 1960, and that death occurred at 3:45 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Michael J. Dausch M.D. 4636 Belair Rd., Baltimore, MD 5/31/60 PHYSICIAN'S NAME (Type) Michael J. Dausch Baltimore, MD, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6/4/60	
22c. NAME OF CEMETERY OR CREMATORIAL Moreland Mem Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14		24a. REC'D BY REGISTRAR DATE JUN 2 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5495

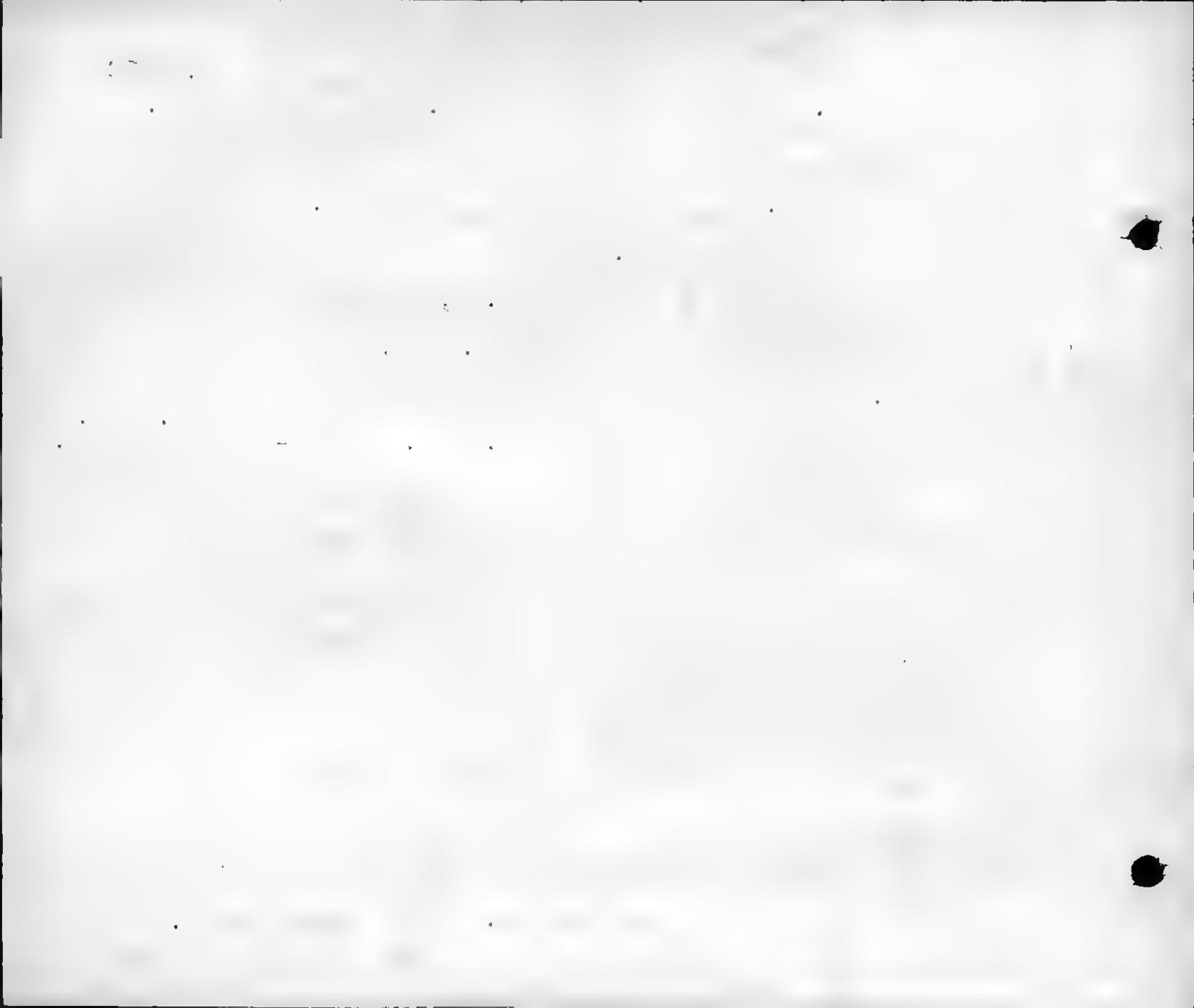
CERTIFICATE OF DEATH

05473

1. PLACE OF DEATH a. COUNTY Balto.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 7		c. LENGTH OF STAY IN 1b Baltimore 7	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7108 Campfield Rd.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7	
3. NAME OF DECEASED (Type or print) LEOLA		First M.	Middle KINSTLER
4. SEX female	5. COLOR OR RACE white	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH Feb. 14, 1892
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. AGE (In years last birthday) 68 yrs.	
10a. KIND OF BUSINESS OR INDUSTRY at home		10b. BIRTHPLACE (State or foreign country) Wash., D. C.	
11. CITIZEN OF WHAT COUNTRY? USA		12. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
13. FATHER'S NAME Edward S. How		14. MOTHER'S MAIDEN NAME Mary Kelsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Roy W. Kinstler - 7108 Campfield Rd.		18. ADDRESS Balto. 7, Md.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X		20. INTERVAL BETWEEN ONSET AND DEATH 1 month	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		21. CHRONIC MYOCARDITIS HYPERTENSION 2 yrs.	
22. DUE TO None		23. DUE TO None	
24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Mild C. V. A. - 1 wk.		25. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
26a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		26b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) None	
26c. TIME OF INJURY Hour a. m. 19 p. m.		26d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
26e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		26f. (City or town) None	
(County)		(State)	
27. I certify that (I) (this hospital) attended the deceased from April 18, 1958 to May 12, 1960 , that (I) (we) last saw the deceased alive on May 16, 1960 and that death occurred at M. from the causes and on the date stated above.		28. DATE SIGNED 25/10/60	
29a. SIGNATURE James A. Miller M.D.		29b. ATTENDING PHYS M.D.	
29c. PHYSICIAN'S NAME (Type) James A. Miller M.D.		29d. MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
29e. ADDRESS 1331 Reisterstown Rd. Pikesville, Md.		29f. DATE SIGNED 25/10/60	
30a. BURIAL, CREMATION REMOVAL (Specify) Burial		30b. DATE THEREOF 5/19/60	
30c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge Cem.		30d. LOCATION (City, town or county) Pikesville, Md.	
30e. (State)		(State)	
31. FUNERAL DIRECTOR'S SIGNATURE John J. Vickerter & Sons - Balt. 17		32a. REC'D BY REGISTRAR DATE MAY 19 '60	
32b. REGISTRAR'S SIGNATURE John J. Vickerter			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

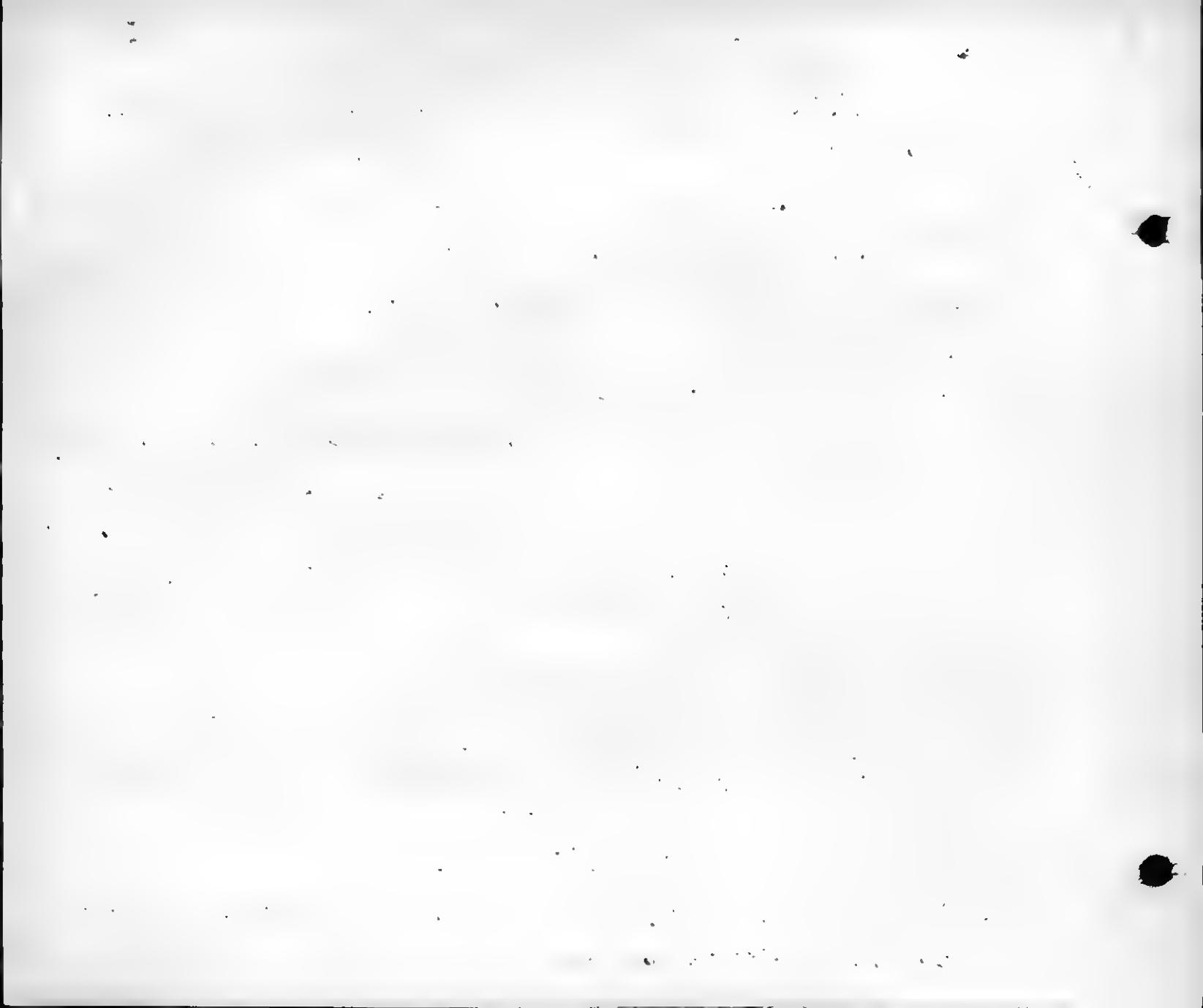


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 14 File No. 5-19-60 et
CERTIFICATE OF DEATH

05474
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baldwin		c. LENGTH OF STAY IN 1b 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Alliston Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 1 Alliston Drive	
3. NAME OF DECEASED (Type or print) Mrs. Margaret V. Klein	First Margaret	Middle V.	Last Klein
4. DATE OF DEATH May 11th	Month May	Day 11	Year 1960
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Ex	8. DATE OF BIRTH Mar. 29, 1894
9. AGE (In years, last birthday) 66 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY 11.	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME ?	14. MOTHER'S MAIDEN NAME Minderlein	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. INFORMANT Mrs. Henry Horner Alliston Dr. Baldwin
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 4/20/60 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis (c) Angina Pectoris DUE TO (b) 2 months (c) 2 months DUE TO (c) 5 yrs. INTERVAL BETWEEN ONSET AND DEATH		18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardiogas. Dis.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Hour a. m. p. m. — 19	Month May	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> —	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) —	(County) —	(State) —	
21. I certify that I attended the deceased from 4/13 , 19 59 , to 5/11 , 19 60 that I last saw the deceased alive on 4/5/60 , and that death occurred at 9:50 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) FORK, MD.	
ACTUAL SIGNATURE Clifford F. Lidson		DATE SIGNED 5/13/60	
PHYSICIAN'S NAME (Type) CLIFFORD F. LIDSON			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/14/60	22c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cem.	22d. LOCATION (City, town, or county) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14	ADDRESS Leonard J. Ruck 5305 Harford Road #14	24a. REC'D BY REGISTRAR DATE MAY 13 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline



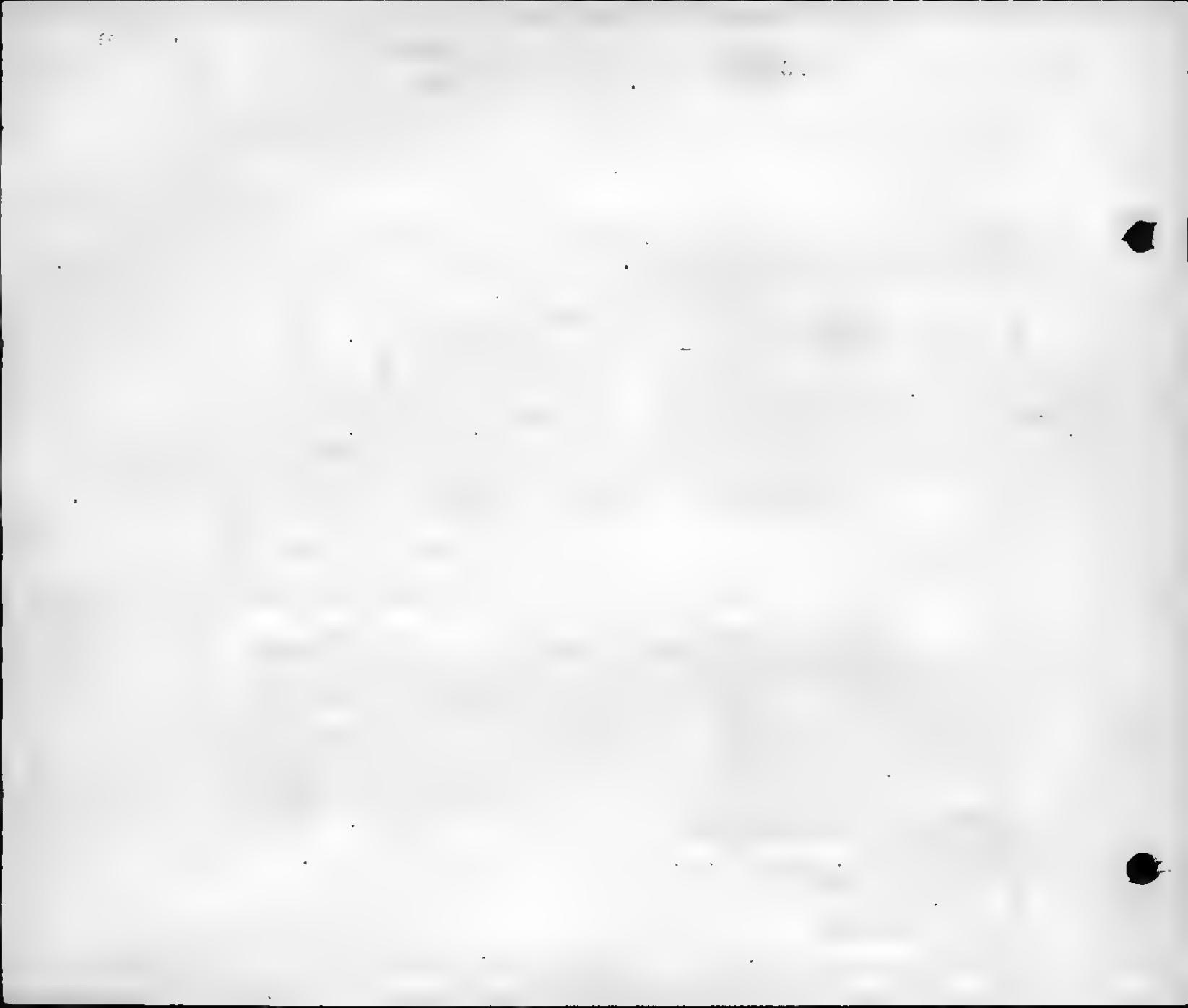
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4
5405

CERTIFICATE OF DEATH

05475
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b 36 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		d. STREET ADDRESS 11822 Reisterstown Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11822 Reisterstown Road						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Anna		First	Middle May	Lost Knight	4. DATE OF DEATH May 17 1960	Month	Day	Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5 1889		9. AGE (In years lost birthday) 71 yrs.	(IF UNDER 1 YEAR) Months 71		(IF UNDER 24 HRS) Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Hendricks				14. MOTHER'S MAIDEN NAME Samanah Fleck					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Elsie K Meekins Reisterstown Md		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C-V Disease						INTERVAL BETWEEN ONSET AND DEATH 3 yrs.			
f2 2.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO									
{ DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) none		(County)	(State)
21. I certify that I attended the deceased from 7-6-38 , 19, to 5-17-60 , 19, that I last saw the deceased alive on 5-17-60 , 19, and that death occurred at 6:45 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE D. D. Caples						ADDRESS (Street, city or town, state) 6 Hanover Rd.		DATE SIGNED 5-19-60	
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 20 1960		22c. NAME OF CEMETERY OR CREMATORIUM Lorraine Park Cemetery		22d. LOCATION (City, town, or county) Baltimore		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mr. Berryman & Sons		ADDRESS Reisterstown Md		24a. REC'D BY REGISTRAR DATE MAY 23 '60		24b. REGISTRAR'S SIGNATURE Charles S. Thomas			



1 X
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

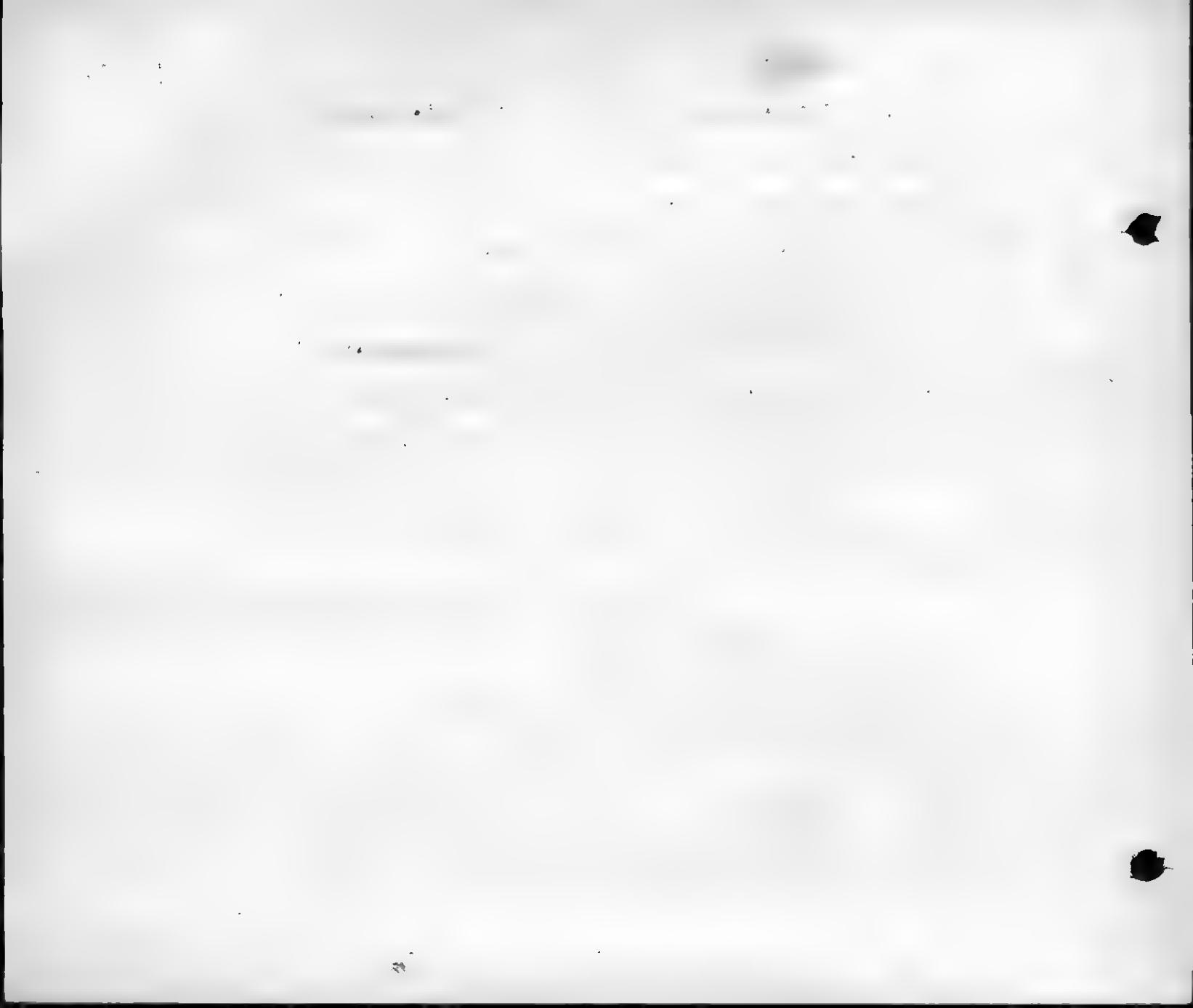
05476

5497

1. PLACE OF DEATH a. COUNTY BALTIMORE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE				c. LENGTH OF STAY IN 1b 9 YRS.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1614 CAPE MAY ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First FLORENCE	Middle H.	4. DATE OF DEATH KNIGELY		Month MAY	Day 15	Year 1960			
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 30, 1879		9. AGE (In years last birthday) 80 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. BIRTHPLACE (State or foreign country) W. VA.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME AARON HAWKINS				14. MOTHER'S MAIDEN NAME ELIZABETH MICHAEL				Address ABOVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 473X <i>Ca. Abnormal</i> <i>haemorrhage</i>									12 hrs		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>On pneumonia</i>									2 or 3 wks		
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Severely disabled after MS diagnosis, & deceased</i>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 1960, to May 15 , 1960, that (I) (we) last saw the deceased alive on May 15 , 1960, and that death occurred at 11:58 P.M. from the causes and on the date stated above.				22a. SIGNATURE <i>J. PLATT, M.D.</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 5/16/60			
22c. PHYSICIAN'S NAME (Type) J. PLATT, M.D.				22d. ADDRESS East. Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-19-60		23c. NAME OF CEMETERY OR CREMATORIAL BLACKSVILLE CEMETERY			23d. LOCATED ON (City, town, or county) BLACKSVILLE (State) PENNA				
24. FUNERAL DIRECTOR'S SIGNATURE HENRY W. JENKINS & SONS CO. 4905 YORK RD.				ADDRESS		25a. REC'D BY REGISTRAR MAY 20 '60		25b. REGISTRAR'S SIGNATURE WILLIAM S. KELLY			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.



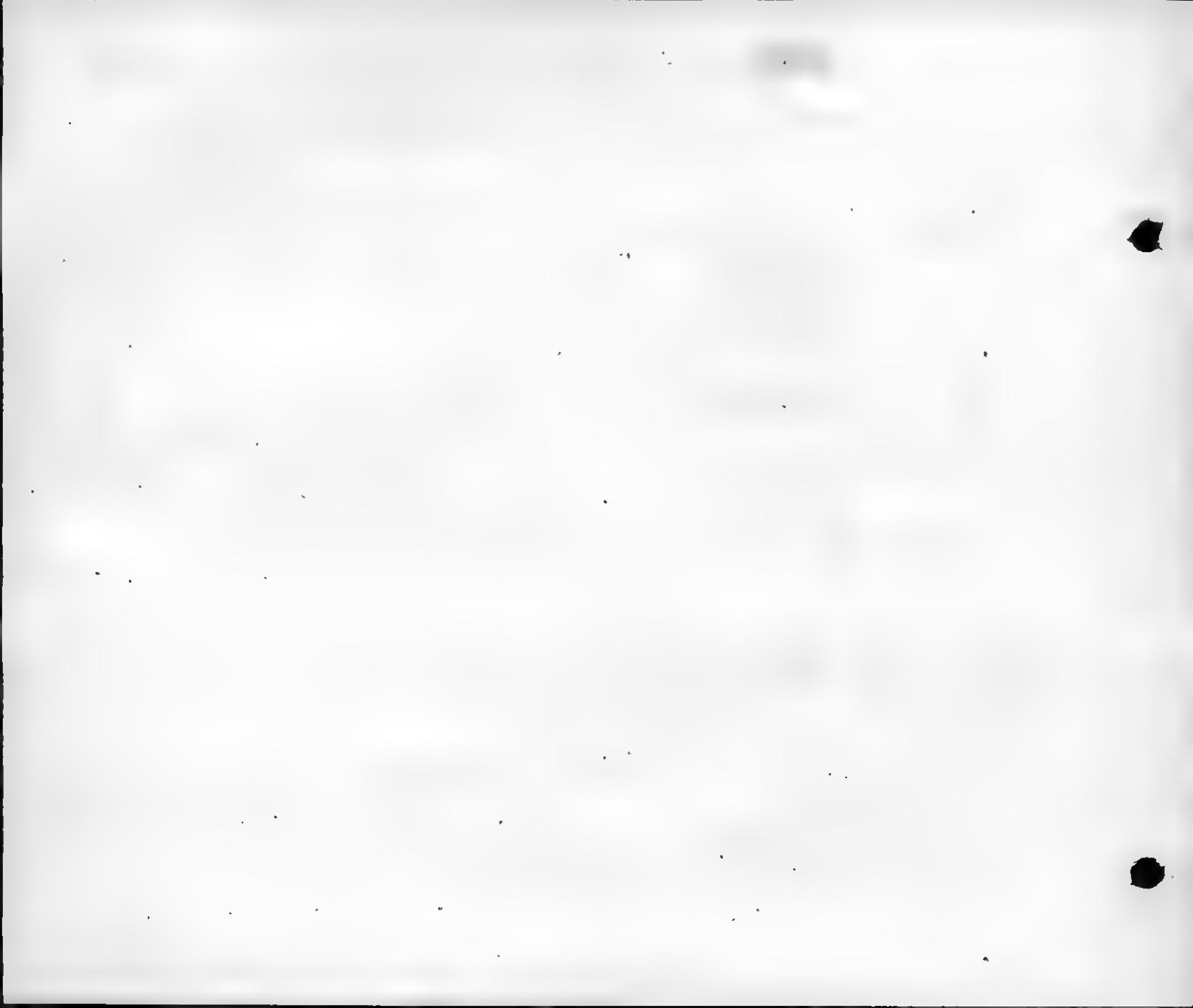
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5498

CERTIFICATE OF DEATH

Reg. No. 05477

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHASE MD		c. LENGTH OF STAY IN 1b LIVE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 249 EBENEZER RD.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CAROLINE	Middle M	Last KNOCHE
4. DATE OF DEATH	Month MAY	Day 30	Year 1960
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 13, 1876
9. AGE (In years last birthday) 84 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	12. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME PHILLIP SCHAADT	14. MOTHER'S M AIDEN NAME CHRISTINE VOLTZ	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. NONE	17. INFORMANT MRS. MARIE McBRIDE	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO DUE TO (c)	
Cerebro-Vascular thrombosis arteriosclerotic Cardio-Vascular disease			19. INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1 , 1960, to May 30 , 1960, that I last saw the deceased alive on May 29 , 1960, and that death occurred at 2:30 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE M. Baumgardner	ADDRESS (Street, city or town, state) BALTIMORE MD		
PHYSICIAN'S NAME (Type) G. M. Baumgardner	DATE SIGNED 5/31/60		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6/2/1960	22c. NAME OF CEMETERY OR CREMATORIUM LORRAINE PARK CEM.	22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home 7401 Belair Rd #6	ADDRESS	24a. REC'D BY REGISTRAR DATE JUN 1 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

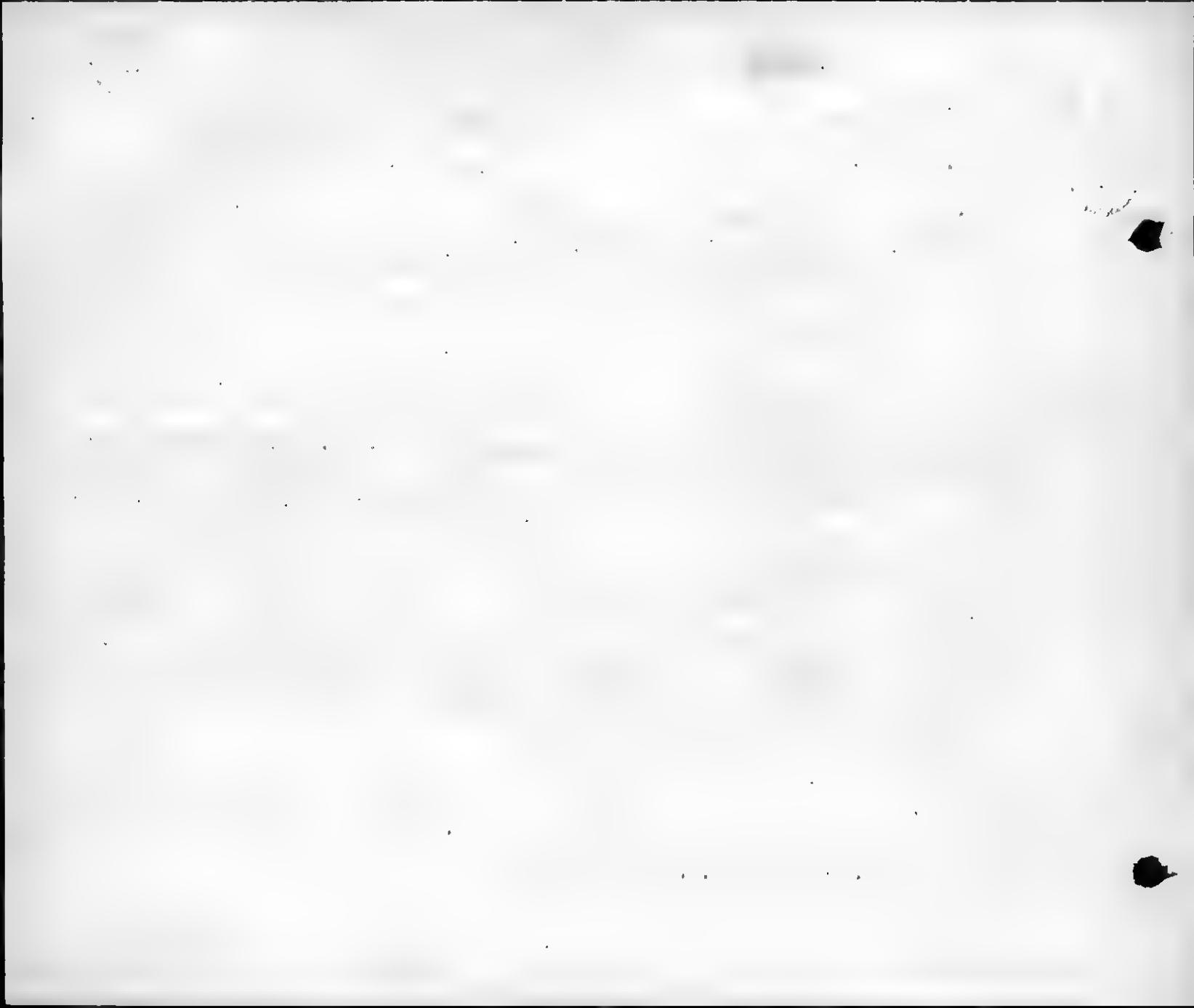
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CERTIFICATE OF DEATH

Reg. Dist. No.

05478
ist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore County			MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland			c. LENGTH OF STAY IN lb		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital			e. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)		
			a. STATE Maryland		
			b. COUNTY Baltimore		
			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 24		
			d. STREET ADDRESS 824 S. Milton Avenue		
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) FRANK STANLEY KUCHAREK			First	Middle	4. DATE OF DEATH Month MAY Day 23 Year 1960
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6.7.1908.	9. AGE (In years lost birthday) 51 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam fitter on construction			10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland		
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JOSEPH KUCHAREK			14. MOTHER'S MAIDEN NAME FRANCES MARCEK		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown			16. SOCIAL SECURITY NO 212-09-5260 INFORMANT Hospital Roads, Mt. Wilson State Hospital Address		
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) For advanced bilateral cavity pulmonary - DUE TO 602X Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 14 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary emphysema. pneumococcosis			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10.19. , 19 55 , to 5. 23. , 19 60 , that I last saw the deceased alive on May 23 , 19 60 , and that death occurred at 11:12 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Wm. Newcomer, M.D. DATE SIGNED Mt. Wilson, Maryland					
ACTUAL SIGNATURE Wm. Newcomer M.D. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5-28-60	22c. NAME OF CEMETERY OR CREMATORIAL Holy Rosary Cemetery	22d. LOCATION (City, town, or county) BALTO. Co MD	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE JHN M. WEBERT & SONS INC			ADDRESS 401 S. CHESTER ST	24a. REC'D BY REGISTRAR DATE MAY 25 '60	24b. REGISTRAR'S SIGNATURE Orther S. Krause



may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

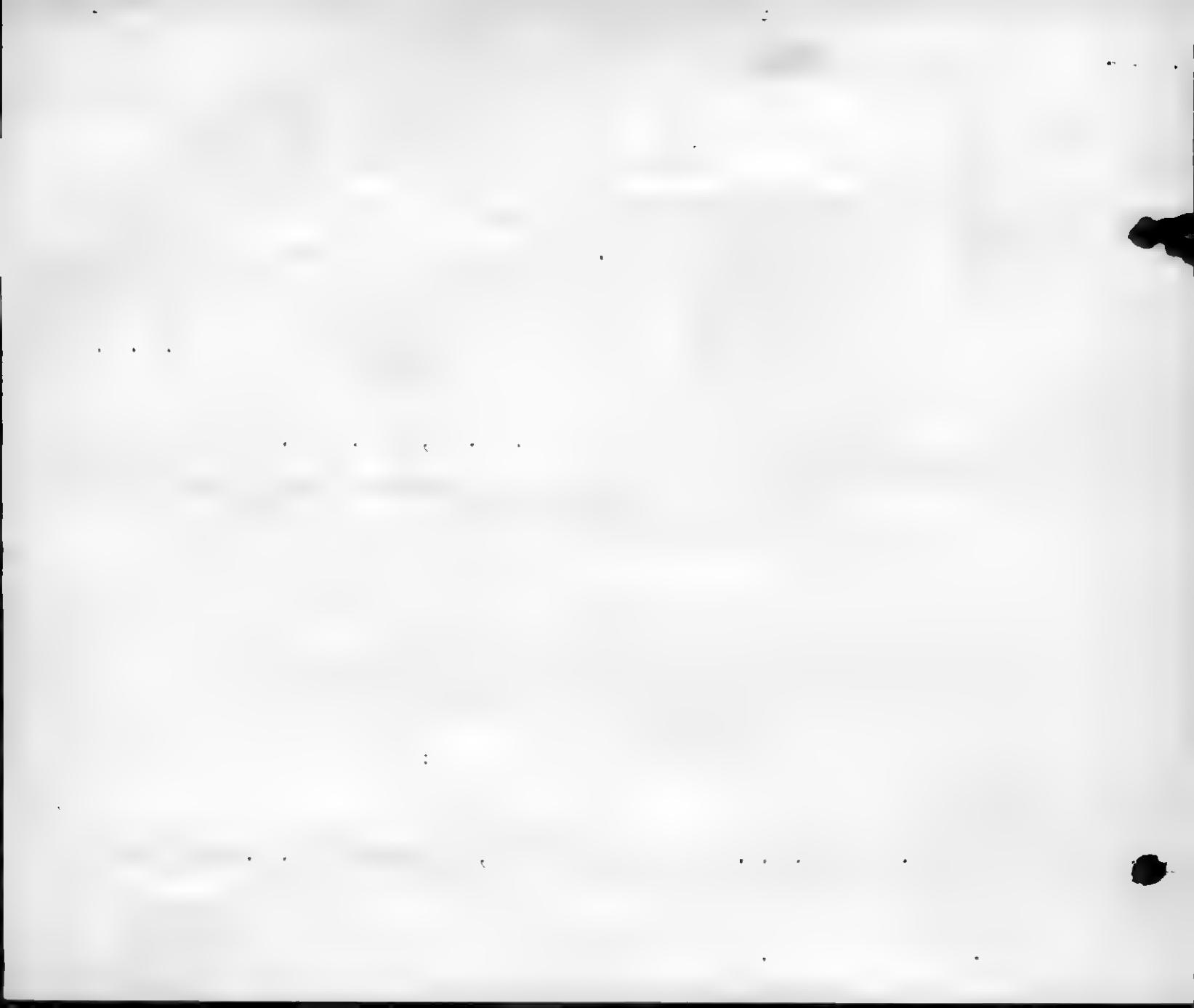
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

05479

5500

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 8 Days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (18) 314-14				
3. NAME OF DECEASED (Type or print)		First GEORGE	Middle W.	Last LaCROIX	4. DATE OF DEATH May			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH March 7, 1893		9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic- Retired			10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Euguen LaCroix				14. MOTHER'S MAIDEN NAME Ginny Bell Hughes				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes			16. SOCIAL SECURITY NO. WW I 215-05-7059		17. INFORMANT Clin.Rec.VAH,Balto.18,Md.Fort Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF COLON WITH METASTASES TO LUNG INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 15-3-8 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) RIGHT ADRENAL AND LIVER (c) CACHEXIA								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION LISTED IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 3 1960 to May 11 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 11 1960 , and that death occurred at VAH , from the causes and on the date stated above								
22a. SIGNATURE <i>John D. Talbert</i>				22b. DATE SIGNED 5/12/60				
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BLRAL. CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 5/14/60				
23c. NAME OF CEMETERY OR CREMATORIAL Greenmount Crematory				23d. LOCATION (City, town, or county) Baltimore Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE Wm. COOK-BLIGHT, INC.				25a. REC'D BY REG STRR DATE MAY 18 1960				
ADDRESS 6009 Harford Road Baltimore 14 Md				25b. REGISTRAR'S SIGNATURE Arthur J. Hayes				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5511

CERTIFICATE OF DEATH

05480

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere		c. LENGTH OF STAY IN 1b 12 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Edgemere (19)		d. STREET ADDRESS / 3207 Whiteway Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3207 Whiteway Road				d. STREET ADDRESS / 3207 Whiteway Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First THOMAS	Middle EDWARD	Last LAWLIS	4. DATE OF DEATH May 26th, 1960	Month May	Day 26	Year 1960
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1905	9. AGE (in years last birthday) 55 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Orfey Lawlis		14. MOTHER'S MAIDEN NAME Dora ?? (Unknown)						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-07-8222		17. INFORMANT Irene Lawlis		Address same as #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Acute myocardial infarction				INTERVAL BETWEEN ONSET AND DEATH 1/2 hr		
(b) DUE TO Chronic congestive heart failure						2 years		
(c) DUE TO Abdominal atherosclerosis - resected 5 years ago		Hypertensive arterosclerotic heart disease				5 years.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) M.D. 914 D Street		(County) (State)
21. I certify that I attended the deceased from July 1, 1957 to May 26, 1960, that I last saw the deceased alive on May 26, 1960, and that death occurred at 3:30 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Sparrows Point 19, Maryland		DATE SIGNED 5/26/60
ACTUAL SIGNATURE John V. Conway, M.D.								
PHYSICIAN'S NAME (Type) John V. Conway, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/31/60		22c. NAME OF CEMETERY OR CREMATORIAL Floral Hills Memorial		22d. LOCATION (City, town, or county) Clarksburg, West Virginia		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Jr.		ADDRESS Dundalk 22, Md.		24a. REC'D BY REGISTRAR DATE JUN 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5512 CERTIFICATE OF DEATH

05481

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) ONNA		First L	Middle LESTER Jr.
4. DATE OF DEATH May 4 1960		Month May	Day 4
5. SEX Male		6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH March 15, 1916		9. AGE (in years last birthday) 44 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Contracting	11. BIRTHPLACE (State or foreign country) Americus, Georgia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Onna L Lester, Sr	
14. MOTHER'S MAIDEN NAME Mattie Wilson		15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. 219-07-7533		17. INFORMANT Clin.Rec.VAH Balto 18, Md Ft Howard Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH 1. Week	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA		DUE TO MALIGNANT NEPHROSCLEROSIS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1151		(b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that THOMAS R. HOOD (this hospital) attended the deceased from May 2 1960 to May 4 1960 that we last saw the deceased alive on May 4 1960 and that death occurred at 11:55 PM , from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE Thomas R. Hood		M.D. <input type="checkbox"/> ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) THOMAS R. HOOD M.D.		22d. ADDRESS VAH Balto 18, Md Ft Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/9/60	
23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		23d. LOCATION (City, town, or county) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S Phillips 1908 N Monroe St		25a. REC'D BY REGISTRAR DATE MAY 9 '60	25b. REGISTRAR'S SIGNATURE Catherine S. Phillips



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

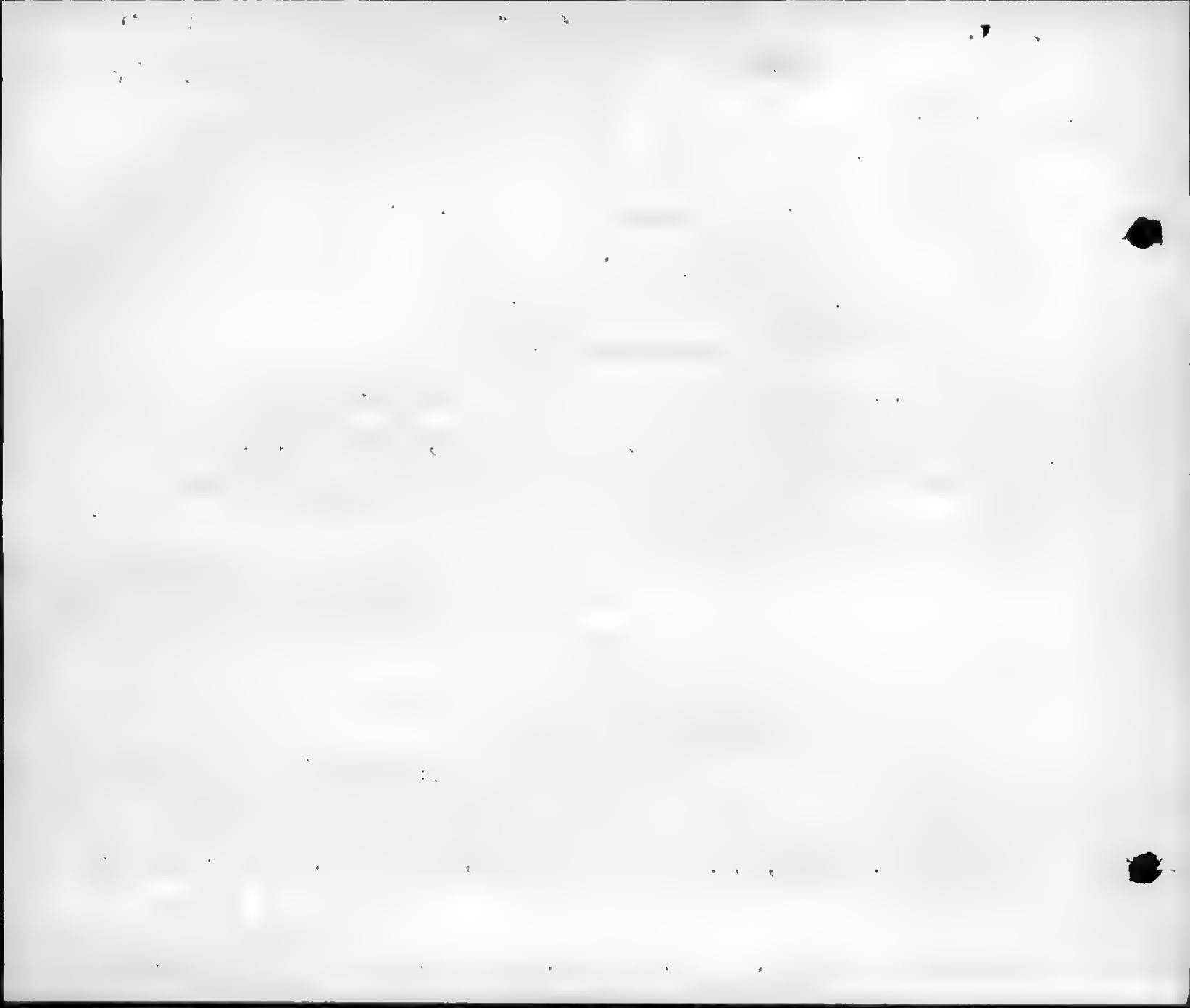
5513

CERTIFICATE OF DEATH

05482

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 70 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3V 14	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 614 E. Fort Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
1. NAME OF DECEASED (Type or print)	First EUGENE	Middle T.	Last LOWMAN	4. DATE OF DEATH MAY 13 1960	Month MAY	Day 13	Year 1960
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> December 26, 1911	9. AGE (In years last birthday) 48 yrs	F. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Diamond Cab Company		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Guy K. Lowman		14. MOTHER'S MAIDEN NAME Rodella Newton					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 217-07-6578		17. INFORMANT ClinRec VAH, Balto 18, Md. Ft. Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) / / / DUE TO ME TASTASES BRONCHOGENIC CARCINOMA RIGHT LUNG WITH WIDESPREAD INTERVAL BETWEEN ONSET AND DEATH Unknown 2 days							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO EDema OF LUNGS					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 4 1960, to May 13 1960, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 13 1960, and that death occurred 5:10AM from the causes and on the date stated above.							
22a. SIGNATURE John D. Talbert				22b. DATE SIGNED 5/13/60			
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.		22d. ADDRESS VAH, BALTO 18, MD. FT. HOWARD DIVISION					
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 5-16-60		23c. NAME OF CEMETERY OR CREMATORIUM Baltimore National		23d. LOCATION (City, town, or county) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE MC CULLY FUNERAL HOME, 130 E. Fort Ave. Balto 30, MD.				ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 16 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5514

CERTIFICATE OF DEATH

05483
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) George		First M.	Middle Lyons
4. DATE OF DEATH May	Month 20	Day 1960	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1889
9. AGE (In years last birthday) 71	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd) Executive	11. KIND OF BUSINESS OR INDUSTRY Balto. Gas & Electric Co	12. BIRTHPLACE (State or foreign country) Baltimore
13. FATHER'S NAME George W. Lyons	14. MOTHER'S MAIDEN NAME Mary	15. CITIZEN OF WHAT COUNTRY? U.S. .	
16. SOCIAL SECURITY NO. NO	17. INFORMANT Mr. Gordon Lyons, 5200 Springlake Way, 12	Address	Zone
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 447 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c) <i>Myocardine dilatation</i> <i>Bronchitis -</i> <i>acute subacute lymphatic disease</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Doy, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 18</i> , 1960, to <i>May 18</i> , 1960, that I last saw the deceased alive on <i>May 18</i> , 1960, and that death occurred at <i>7:30</i> A.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Geo. McLean</i> ADDRESS (Street, city or town, state) <i>705 Med Act</i> DATE SIGNED <i>Geo. McLean</i>			
PHYSICIAN'S NAME (Type) GEO. MCLEAN		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 5-23-60		22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		22d. LOCATION (City, town, or county) Woodlawn, Md (State)	
ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 24 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5515

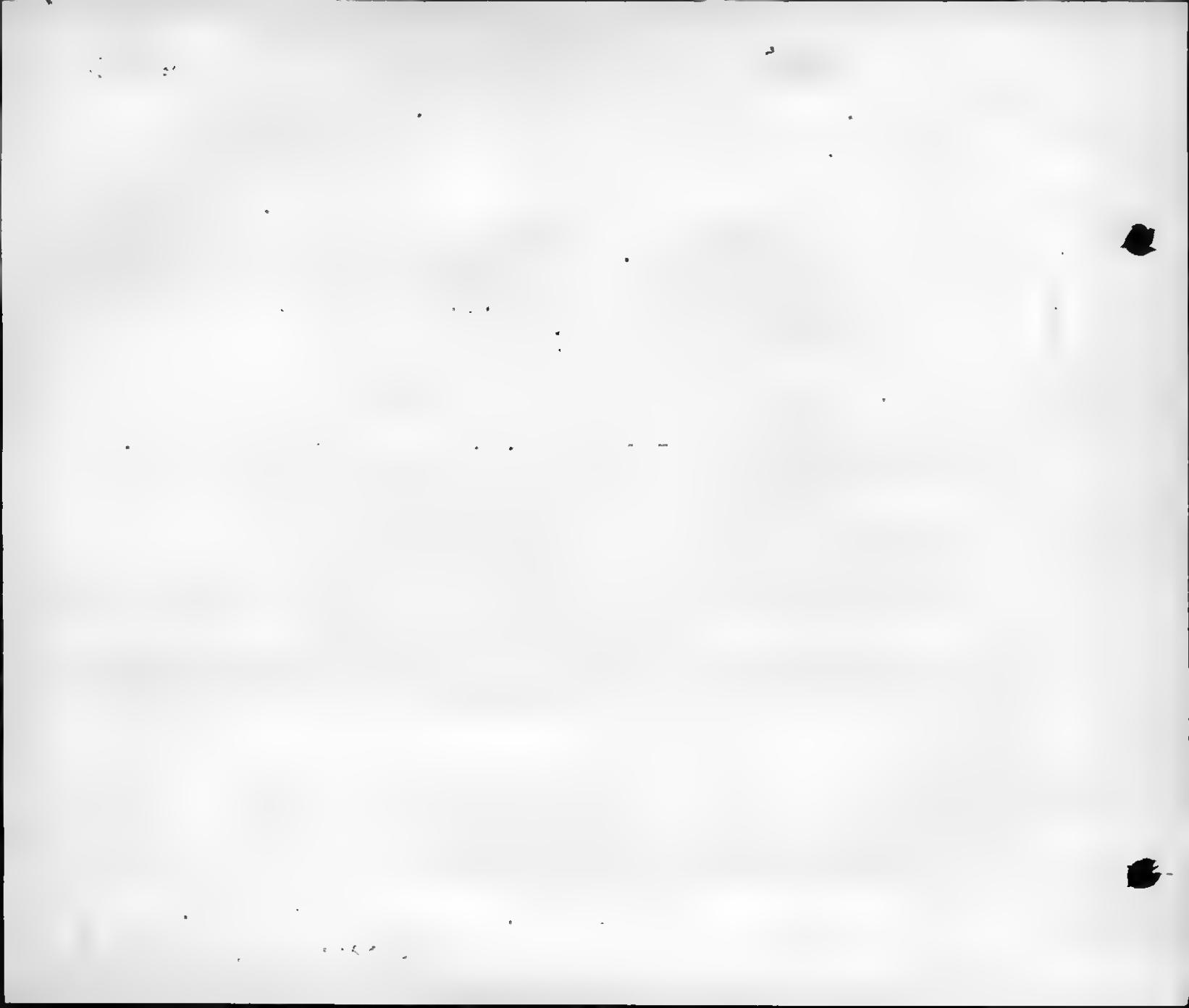
CERTIFICATE OF DEATH

05484

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3 4 11. 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor		d. STREET ADDRESS 5502 Roland Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ALLEN	Middle L.	Last MALONE	4. DATE OF DEATH May 16, 1960	Month May	Day 16	Year 1960
5. SEX male	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 23, 1880	9. AGE (In years last birthday) 79 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Manager		10b. KIND OF BUSINESS OR INDUSTRY Continental Can		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph S. Malone				14. MOTHER'S MAIDEN NAME Kate Latta			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
yes		World War I 091-03-6778		Mrs. E. Morgan Loane		-5502 Roland Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis & Prostatic Enlargement 5 years ago							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that (I) (this hospital) attended the deceased from 1950 to 1960, that (I) (we) last saw the deceased alive on 5/12/1960, and that death occurred at 7 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Franklin E. Leslie				22b. DATE SIGNED 22b. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) Franklin E. Leslie		22d. ADDRESS 2929 N. Charles St.					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/18/60		23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge Cem.		23d. LOCATION (City, town, or county) Pikesville, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Schmitz & Sons - Balto. 17		ADDRESS		25a. REC'D BY REGISTRAR MAY 17 '60		25b. REGISTRAR'S SIGNATURE C. L. & T. Inc.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5394 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05485

Reg. Dist. No.

TO DEATH EXAMINER: This certificate should be executed within 24 hours after death. If any entry is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm #M3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 53		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 218 Detroit Ave.			d. STREET ADDRESS 218 Detroit Ave.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JOHN GEORGE MARQUARDT		First	Middle	Last	4. DATE OF DEATH May 27, 1960
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Dec. 24, 1891		9. AGE (In years (at birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman-ret.		10b. KIND OF BUSINESS OR INDUSTRY Crown Cork Seal		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME William H. Margquardt			14. MOTHER'S MAIDEN NAME Elizabeth Kaiser		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type, no, or unknown) No.		16. SOCIAL SECURITY NO. 213-01-0304		17. INFORMANT Irvin Marquardt 6735 Pine Ave., -22	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1 DUE TO <i>Coronary Occlusion</i> INTERVAL BETWEEN ONSET AND DEATH 3 min Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>A-S-E-V Disease</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> ACTUAL SIGNATURE <i>M.B. Davis</i> DATE SIGNED <i>5/28/60</i> EXAMINER'S NAME (Type) M.B. Davis, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/31/60		22c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn Cemetery	
22d. LOCATION (City, town, or county) Baltimore, Md.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ulrich Funeral Home 2112 Dundalk Ave.		ADDRESS 1112 Dundalk Ave.		24a. REC'D BY REGISTRAR DALE JUN 1 '60	
24b. REGISTRAR'S SIGNATURE C. Davis					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5515

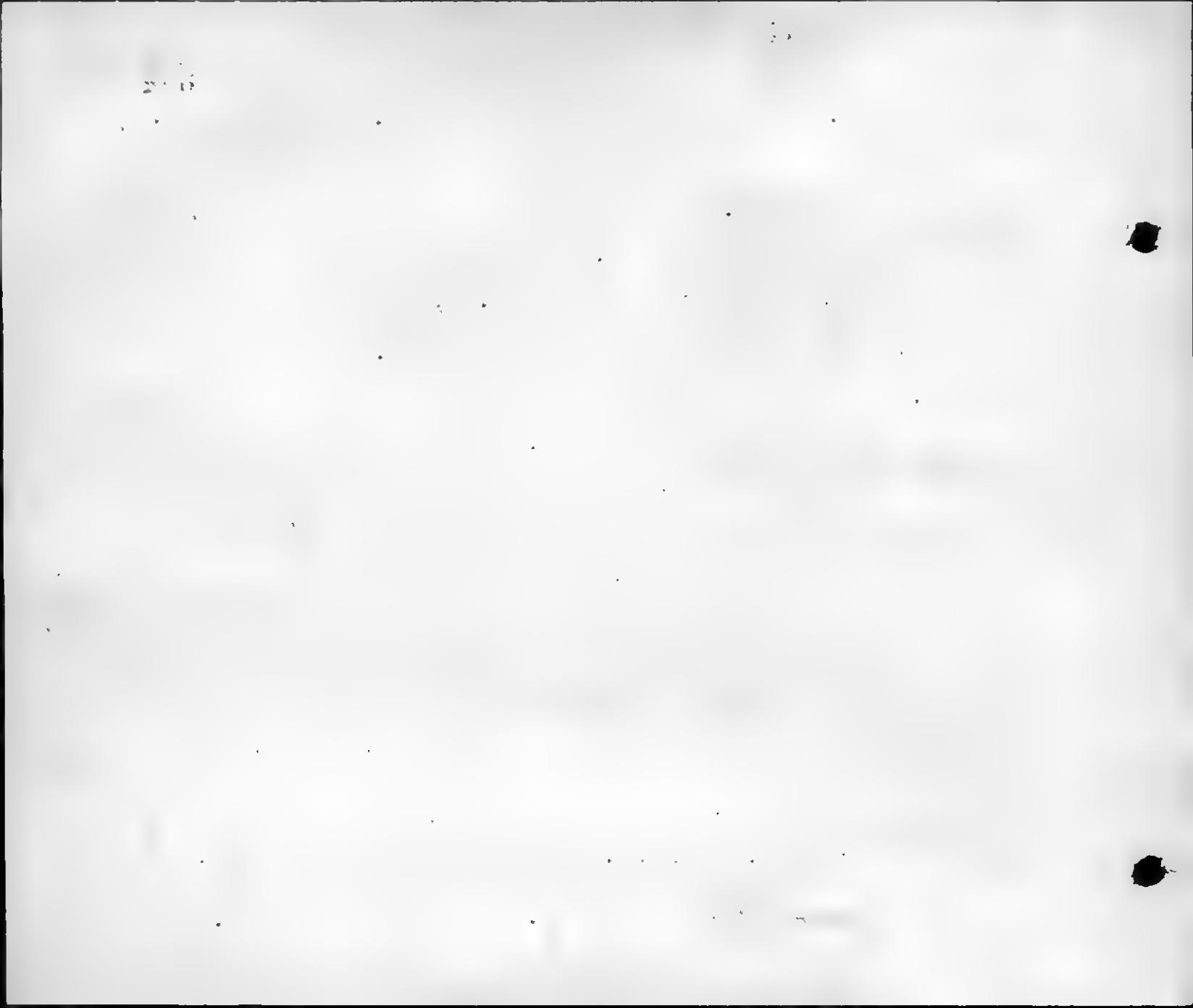
CERTIFICATE OF DEATH

05486

1. PLACE OF DEATH a. COUNTY Balto.		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Milford		c. LENGTH OF STAY IN 1b X Milford	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3705 Buckingham Rd.		d. STREET ADDRESS 3705 Buckingham Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) OLIVE		First F.	Middle MARSHALL
4. DATE OF DEATH May 7, 1960	Month May	Day 7	Year 1960
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1890
9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY at home	
10c. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry W. Fellingame		14. MOTHER'S MAIDEN NAME Arabelle Buckworth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. no	17. INFORMANT Mr. Henry Fellingame - 1602 Waverly Way
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1142 X Conditions, if any, which give rise to immediate cause (a), stating the under- lying cause last		INTERVAL BETWEEN ONSET AND DEATH 4 Mos Cerebral thrombosis, left	
DUE TO (b) Hypertensive arterosclerotic cardiovascular disease		DUE TO (c) know for 7 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from November 1953 to 7 May 1960, that (I) (we) last saw the deceased alive on 7 May 1960, and that death occurred at 3 P. M. from the causes and on the date stated above		22b. DATE SIGNED 9 May 1960	
22c. PHYSICIAN'S NAME (Type) Marvin H. Davis, M. D.		M. D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/9/60	23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cem.
24. FUNERAL DIRECTOR'S SIGNATURE H. F. Siekner & Sons - Balto, Md.		ADDRESS	25a. REC'D BY REGISTRAR DATE MAY 10 '60
			25b. REGISTRAR'S SIGNATURE G. L. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF

5517

CERTIFICATE OF DEATH

45-187

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		d. STREET ADDRESS 162 Winters Lane		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 162 Winters Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) MARY		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year
5. SEX Female		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years (at birthday) yrs.) 86	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Edward Adams		14. MOTHER'S MAIDEN NAME Laura ?						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Mrs Mamie Williams 162 Winters Lane		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		DUE TO Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 9 days		
(b) Hypertensive Arterio-sclerotic Heart Disease DUE TO & Mitral Insufficiency								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Left Hemiplegia 5 yrs 10 mo. 12 days						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 162 Winters Lane		20f. (City or town) Catonsville	(County)	(State)
21. I certify that I attended the deceased from Feb. 5th, 1946 , to May 9th, 1950 , that I last saw the deceased alive on May 9th, 1950 , and that death occurred at 6:00 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE C. F. Maloney, M.D. ADDRESS (Street, city or town, state) 57 Winters Lane DATE SIGNED 5-9-60								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-12-60		22c. NAME OF CEMETERY OR CREMATORIAL Western Star Cem		22d. LOCATION (City, town, or county) Catonsville (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Maet Francis A. Henley		ADDRESS 578 W. Biddle St.		24a. REC'D BY REGISTRAR MAY 12 '60		24b. REGISTRAR'S SIGNATURE J. P. French		



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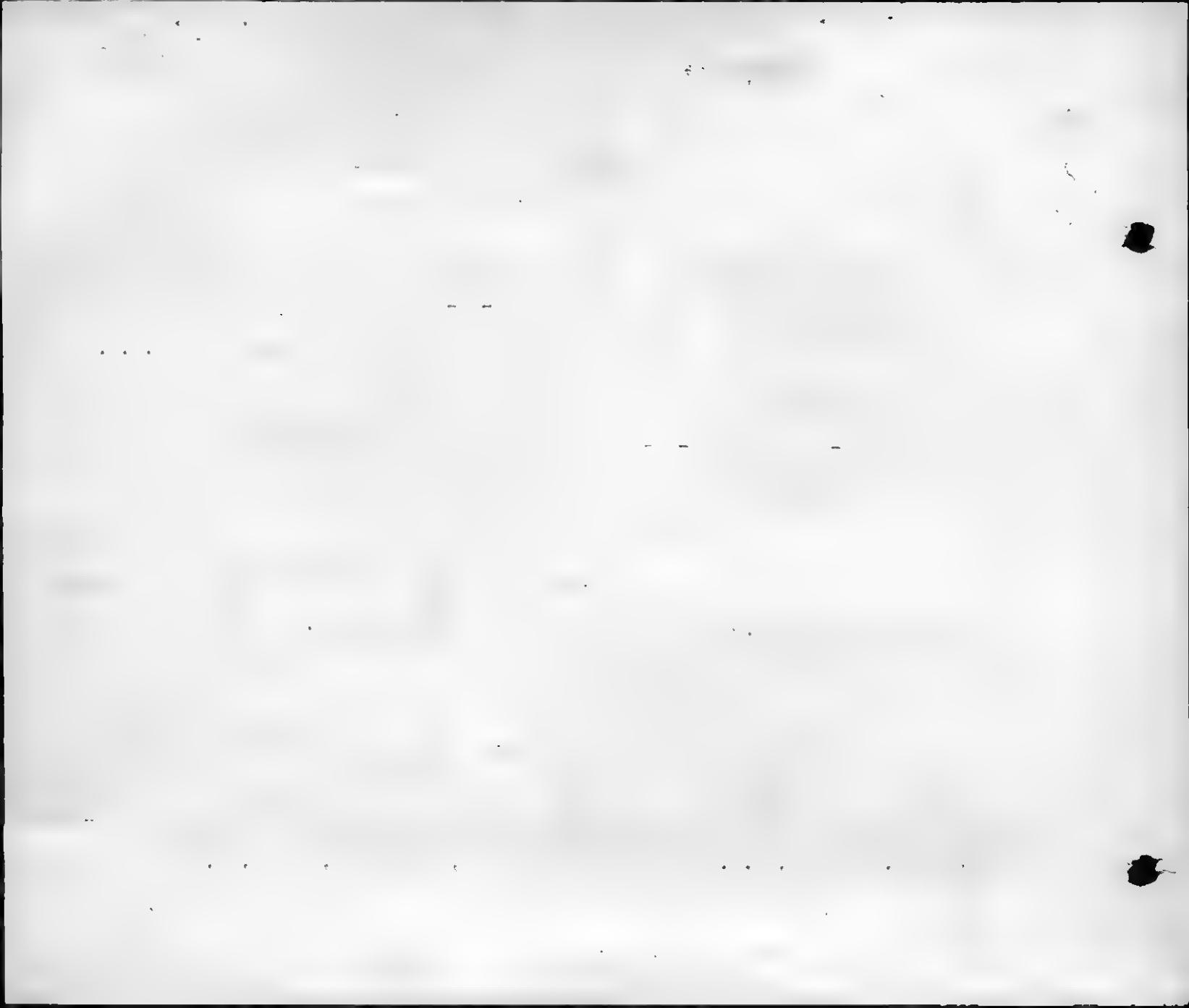
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5518

CERTIFICATE OF DEATH

05488

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 13 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
e. STREET ADDRESS 3335 38th RAMONA AVENUE		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES		First JAMES	Middle
4. DATE OF DEATH MAY 11 1960		Last McCLUSKEY	Month MAY
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-21-90
9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) MARYLAND, BALTIMORE U.S.A.	
13. FATHER'S NAME MICHAEL A McCLUSKEY		14. MOTHER'S MAIDEN NAME ANNA HEALEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 215-34-7298	17. INFORMANT Address CLIN REC VAH BALTIMORE MD FT HOWARD DIVISION
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EDEMA OF LUNGS		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (b) CACHEXIA		UNKNOWN	
DUE TO (c) STATUS POST HEMIGLОСSECTOMY, CARCINOMA OF TONGUE		UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Hemiglосsectomy for carcinoma of tongue		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Operation March 1954. John Hopkins Hospital, Baltimore, Md.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) VAH, BALTIMORE, 18, MD, FT. HOWARD DIVISION
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 28, 1960 to May 11, 1960 . That <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 11, 1960 , and that death occurred 3:10pm from the causes and on the date stated above.		22b. DATE SIGNED 5-12-60	
22c. SIGNATURE John D. Talbert, M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22d. ADDRESS VAH, BALTIMORE, 18, MD, FT. HOWARD DIVISION
22e. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-14-60	23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral Cemetery
24. FUNERAL DIRECTOR'S SIGNATURE SCHIMUNEK FUNERAL HOME		ADDRESS 3331 Brehem's Lane	25a. REC'D BY REGISTRAR Baltimore
			25b. REGISTRAR'S SIGNATURE Calvin S. Kline
			DATE MAY 13 '60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5519

CERTIFICATE OF DEATH

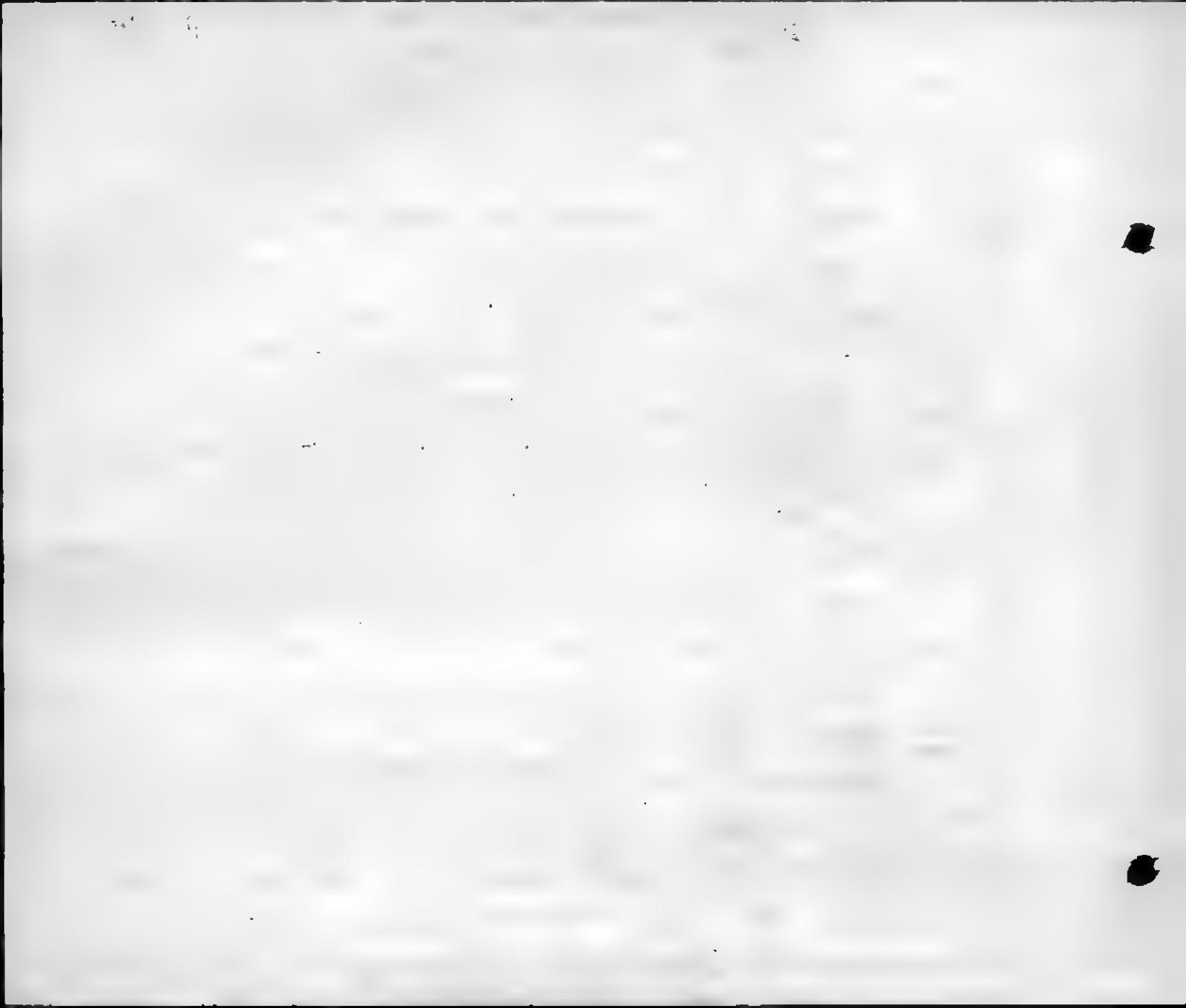
05489

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3513 Jean Drive		d. STREET ADDRESS 3513 Jean Drive #7	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DANIEL WILLIAM McINTIRE		First Middle Last	4. DATE OF DEATH May 7 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Sept. 10, 1875	9. AGE (In years last birthday) 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY Insurance	11. BIRTHPLACE (State or foreign country) Kent County, Maryland
13. FATHER'S NAME Joshua Bruce McIntire		14. MOTHER'S MAIDEN NAME Margaret Ann Lynch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Clara E. McIntire-3513 Jean Drive #7
No		Yes	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
100 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) MALUNION, FRACTURE OF NECK OF RIGHT FEMUR	
20c. TIME OF INJURY Hour a. p. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>FALL</u> , 19 <u>58</u> to <u>MAY 7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>MAY 6</u> , 19 <u>60</u> , and that death occurred at <u>12:05 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 5334 LIBERTY HEIGHTS AVE. 57760 DATE SIGNED	
ACTUAL SIGNATURE MARVIN GOLDSTEIN	PHYSICIAN'S NAME (Type) MARVIN GOLDSTEIN BALTO. I. MD.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/10/60	22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery	22d. LOCATION (City, town, or county) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE am. J. Schlesinger - 12.7.60.	ADDRESS	24a. REC'D BY REGISTRAR DATE MAY 10 '60	24b. REGISTRAR'S SIGNATURE S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH

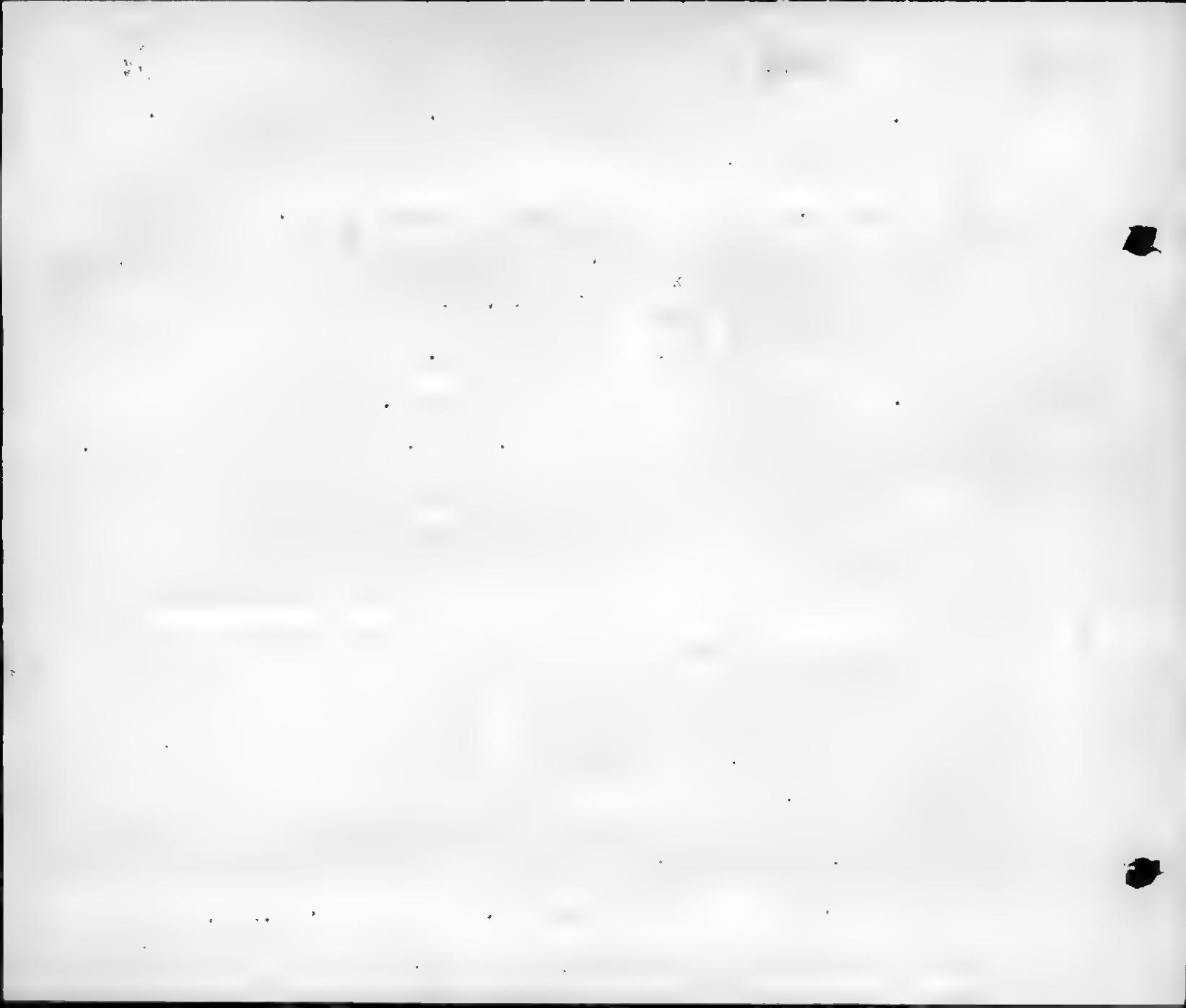
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5520

05490

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Balto.			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Balto.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 7			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 7		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8339 Liberty Rd.			d. STREET ADDRESS 8339 Liberty Rd.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First ALBERT	Middle L.	Last MEHRLING	4. DATE OF DEATH May 21, 1960
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Mar. 12, 1888	9. AGE (In years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Official		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Henry L. Mehrling		14. MOTHER'S MAIDEN NAME Mary A. Adams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mary A. Nehrling - 8339 Liberty Rd.	
no				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic heart disease DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH 1 day					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
5 years					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-7, 1957 to 5-21, 1960, that (I) (we) last saw the deceased alive on 5-17, 1960, and that death occurred at 10 M, from the causes and on the date stated above					
22a. SIGNATURE B. Stanley Cohen, M.D.		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5-23-60	
22c. PHYSICIAN'S NAME (Type) B. Stanley Cohen, M.D.		22d. ADDRESS 7306 Liberty Road Baltimore 7, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/24/60	23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cem.		23d. LOCATION (City, town, or county) Balto. Md. (State)
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tuckner		ADDRESS X-7 Balto 17, Md	25a. REC'D BY REGISTRAR DATE MAY 24 '60		25b. REGISTRAR'S SIGNATURE John E. Evans



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5521 05491

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 98 DAYS	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREENSBORO	
3. NAME OF DECEASED (Type or print) GEORGE		First H	Middle MENDENHALL
4. DATE OF DEATH MAY 12 1960		Month MAY	Day 12
5. SEX MALE		6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH JANUARY 2, 1897		9. AGE (In years lost birthday) 63 yrs	10. IF UNDER 1 YEAR Months 0
10a. US LAB. OCCUPATION (Give kind of work done during most of working life, even if retired) WOOD & METAL WORKER		10b. KIND OF BUSINESS OR INDUSTRY Construction Co	11. BIRTHPLACE (State or foreign country) NORTH CAROLINA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HAMOND MENDENHALL	
14. MOTHER'S MAIDEN NAME TEMPIE MONTGOMERY		15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) YES	
16. SOCIAL SECURITY NO. WW-1		17. INFORMANT CLIN REC VAH BAL TO MD FT HOWARD DIVISION	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INANITION DUE TO CARCINOMA OF THE STOMACH INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND T ON GIVEN IN PART 1(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEBRUARY 4 1960 to MAY 12 1960 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MAY 12 1960 , and that death occurred 10:00 AM from the causes and on the date stated above			
22a. SIGNATURE <i>John D. Talbert</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED 5/13/60
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT		22d. ADDRESS VAH FT HOWARD, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 5-13-1960	23c. NAME OF CEMETERY OR CREMATORIUM MAPLE WOOD CEMETERY
23d. LOCATION (City, town or county) GREENSBORO		(State) NORTH CAROLINA	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S Phillips		25a. ADDRESS 1808-10 N Monroe St Baltimore 17 Md	25b. REC'D BY REGISTRAR DATE MAY 20 60
25c. REGISTRAR'S SIGNATURE <i>Indra S. Phillips</i>			



1
FOR STATE
HEALTH DEPT.

Please execute this certificate, writing the word "pending" in pencil in lines 18, 20 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR Page 1 should be used as a burial-transit permit. File Page 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

552 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY
Baltimore

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
8200 Pulaski

3. NAME OF
DECEASED
(Type or print)
JAMES First
C. Middle

4. SEX
Male

5. COLOR OR RACE
white

6. MARRIED NEVER MARRIED b. DATE OF BIRTH
WIDOWED DIVORCED
May 2, 1909

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
none

10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
Wisconsin

12. CITIZEN OF WHAT COUNTRY
U.S.A.

13. FATHER'S NAME
Mose A. Meredith

14. MOTHER'S MAIDEN NAME
Susan Drout

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes, give rank or date of service)
YES **WW II** **John J. Meredith, 207 Mt. Washington Street**
Alexanderia Va.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)
Coronary Occlusion

DUE TO
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.
(b)
DUE TO
(c)
Myocardial infarct.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e), 19. WAS AUTOPSY PERFORMED?
 YES NO **Partial**

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. **19** 20d. INJURY OCCURRED While Not While 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
at work at work home **PARTIAL** 20f. (City or town)
(County) **Baltimore, Md.** (State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from. Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE 

EXAMINER'S NAME (Type)
William J. Cook

CHIEF MEDICAL EXAMINER
M.D. ASSISTANT MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER

DATE SIGNED
May 5, 1960

Address (Street, city, town, or county)
William Cook, Inc., 1217 St. Paul Street

22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL 22b. DATE THEREOF
5-9-60 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS
Arlington National Cemetery

22d. LOCATION (City, town, or county)
Arlington, Virginia (State)

23. FUNERAL DIRECTOR
William Cook, Inc., 1217 St. Paul Street

24a. REC'D BY REGISTRAR
May 9 '60 24b. REGISTRAR'S SIGNATURE
Arthur S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5523

CERTIFICATE OF DEATH

65493

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Arrapost N.H., Sherwood & Regester		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS 408 Aigburth Ave. 4	
3. NAME OF DECEASED (Type or print) JOHN		First N	Middle MERKLE
4. DATE OF DEATH May 5 1960		Month May	Day 5
5. SEX Male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH April 18, 1894		9. AGE (In years from birthday) 66 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President		10b. KIND OF BUSINESS OR INDUSTRY Machine Shop	
11. BIRTHPLACE (State or foreign country) New York, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John N. Merkle		14. MOTHER'S MAIDEN NAME Catherine Hess	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT 212-910-7360 John A. Merkle 115 Overbrook Rd 12	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Sudden Hypertension Atherosclerotic Cardio-renal / Vascular Disease 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1951</u> to <u>May 5, 1960</u> that I last saw the deceased alive on <u>May 3, 1960</u> , and that death occurred at <u>7501 York Rd</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Charles F. O'Donnell 7501 York Rd Md. Charles F. O'Donnell M.D. Towson Co. Md.	
ACTUAL SIGNATURE		DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/9/60	
22c. NAME OF CEMETERY OR CREMATORIAL Dulaney Mem. Gardens		22d. LOCATION (City, town, or county) Timonium Patco Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson Inc. 1050 York Rd 4		24a. REC'D BY REGISTRAR DATE MAY 6 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, and in any event, within 72 hours after death, return this certificate to the State Board of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										05494					
5524					CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			d. STREET ADDRESS 7 Locust Drive, Larchmont		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home															
3. NAME OF DECEASED (Type or print)		First Elsie Schellhas		Middle Merryman	Last		4. DATE OF DEATH May 30		Month	Day	Year				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Nov. 30, 1886		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland				12 CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Charles Schellhas						14. MOTHER'S MAIDEN NAME Bertha ?									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <small>(If yes, give war or dates of service)</small>				16. SOCIAL SECURITY NO				17. INFORMANT Mrs. George Klinefelter				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 19.2 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)												Terminal Cerebrovascular with general metastases			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 2/10/58 , 19, to 5/22/60 , 19, that (I) (we) last saw the deceased alive on 5/22/60 , 19, and that death occurred at M , from the causes and on the date stated above.															
22a. SIGNATURE Milton Schlenoff				M.D. <input type="checkbox"/> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN				22b. DATE SIGNED 1960							
22c. PHYSICIAN'S NAME (Type) Dr. Milton Schlenoff				22d. ADDRESS 6410 Windsor Mill Road											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-2-60		23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge				23d. LOCATION (City, town, or county) Pikesville, Maryland		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc. 1900 Eutaw Place						ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 2 '60		25b. REGISTRAR'S SIGNATURE Charles S. Thomas					

Y MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any
certificate, writing the word "pending," in pencil, in Item 18. Give Pages 1 and 3 to the funeral
director. Page 4 should be retained for your files.
The Chief Medical Examiner's Office along with form PM3. Page
3 should be used as a burial transfer.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5525 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05495

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Baltimore</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Calverville</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>57 Calverville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>6118 Old Frederick Rd</i>			d. STREET ADDRESS <i>6118 Old Frederick Rd</i>		
3. NAME OF DECEASED (Type or print) <i>Jessie Bennett Morris</i>		First	Middle	Last	4. DATE OF DEATH <i>Sept 25</i>
5. SEX <i>7</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <i>May 3 1903 57</i>	9. AGE (In years less birthday) yrs. <i>80</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Houswife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>USA</i>	
13. FATHER'S NAME <i>Bennett Bridgford</i>			14. MOTHER'S MARRIED NAME <i>Sallee Hipes</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Charles Morris, Old Frederick</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Jessie Bennett Morris</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Cardiovascular disease</i> (c) <i>None</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> ACTUAL SIGNATURE <i>Geo. S. M. Kieffer</i> DATE SIGNED <i>May 15, 60</i> EXAMINER'S NAME (Type) <i>Geo. S. M. KIEFFER M.D.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>B</i>		22b. DATE THEREOF <i>5-31-60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore National Cemetery</i>	22d. LOCATION (City, town, or county) <i>Baltimore</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Johnson, 1011 N. Arlington Ave</i>			ADDRESS	24a. REC'D BY REGISTRAR DATE <i>MAY 27 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Charles S. Kieffer</i>

5 may be removed. File pages 1 and 2 with the registrar.

TO
be
forwarded to
or removal.
TO FUNERAL DIRECTOR: page

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05496

CERTIFICATE OF DEATH

Reg. Dist. No.

5526

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Catonsville 28

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospit., give street address)

OR INSTITUTION Paradise Nursing Home
Paradise and Altamont Avenues

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore

d. STREET ADDRESS

4805 Norwood Avenue

111-4

e. IS RESIDENCE
ON A FARM?YES NO

3. NAME OF

(Type or print)

First

Middle

Last

4. DATE
OF
DEATHMonth
MayDay
4Year
1960

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

 NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

March 30, 1883

9. AGE (In years
last birthday)

77 yrs

10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

11. KIND OF BUSINESS OR INDUSTRY

12. CITIZEN OF WHAT COUNTRY?

Housewife

Norfolk, Virginia

U.S.A.

13. FATHER'S NAME

Abraham Myers

14. MOTHER'S MAIDEN NAME

Mary MacRorie

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

16. SOCIAL SECURITY NO.

INFORMANT

Address

Edward Walton, 1st Nat'l Bank Baltimore

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY;
IMMEDIATE CAUSE (a)

Cerebral Hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH

1 week

452-1

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

DUE TO

(b)

Arteriosclerotic cardiovascular disease

10 years

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING

 OR CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. ******** 19
p. m. ********20d. INJURY OCCURRED
While **at work** Not while
at work **at work** 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)
*****20f. (City or town)
(County) *********
(State) *********21. I certify that I attended the deceased from **1950**, to **1960**, and that death occurred at **11 P.M.** on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)

Millard T. Traband, Jr.

M.D. 5101 Gwynn Oak Ave.

5/6/60

Baltimore, 7, Md.

22a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

5-6-60

22c. NAME OF CEMETERY OR CREMATORY

Woodlawn Cemetery

22d. LOCATION (City, town, or county)

Woodlawn

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

William Cook, Inc., 1217 St. Paul Street

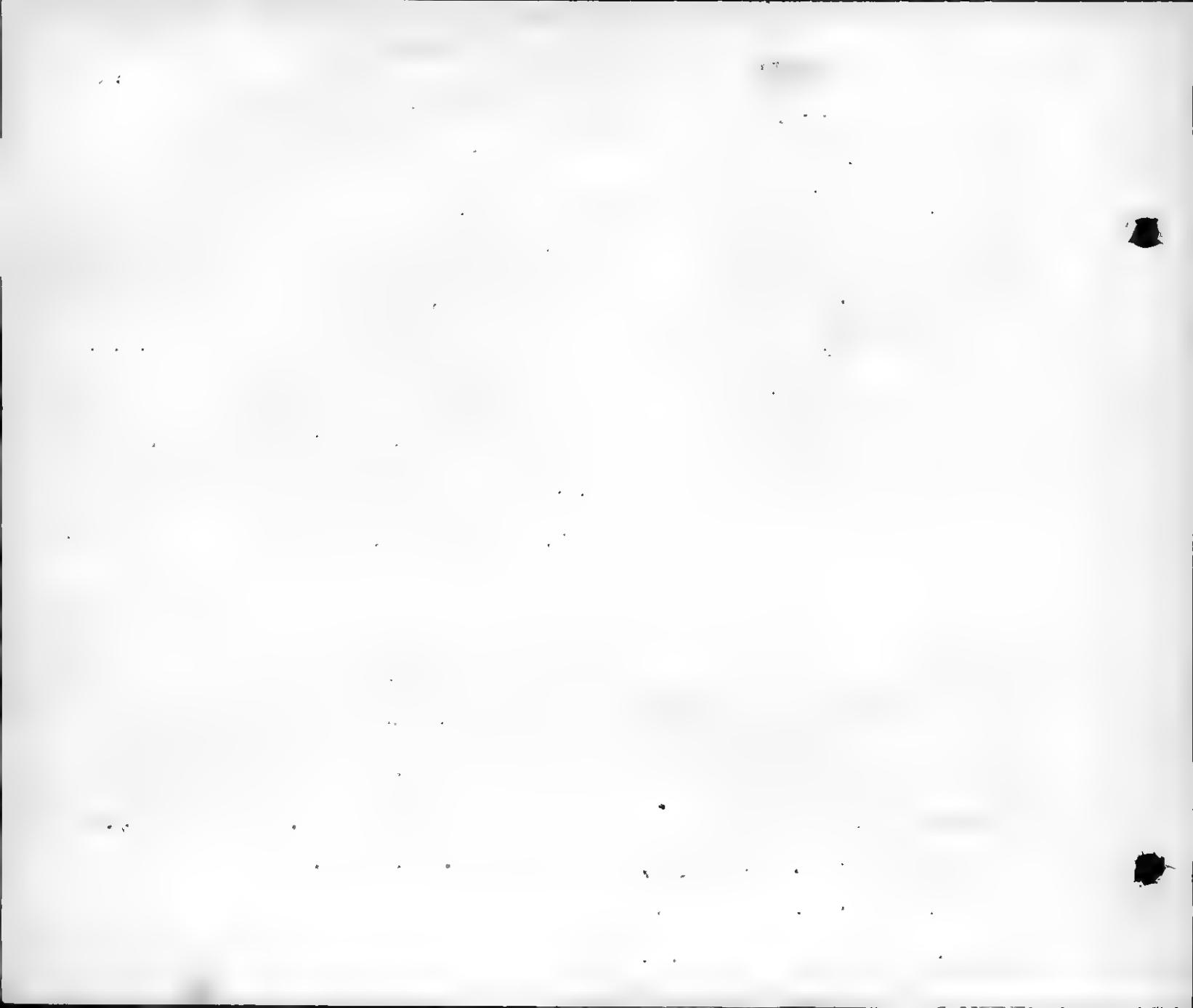
ADDRESS

24a. REC'D BY REGISTRAR

MAY 9 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5527

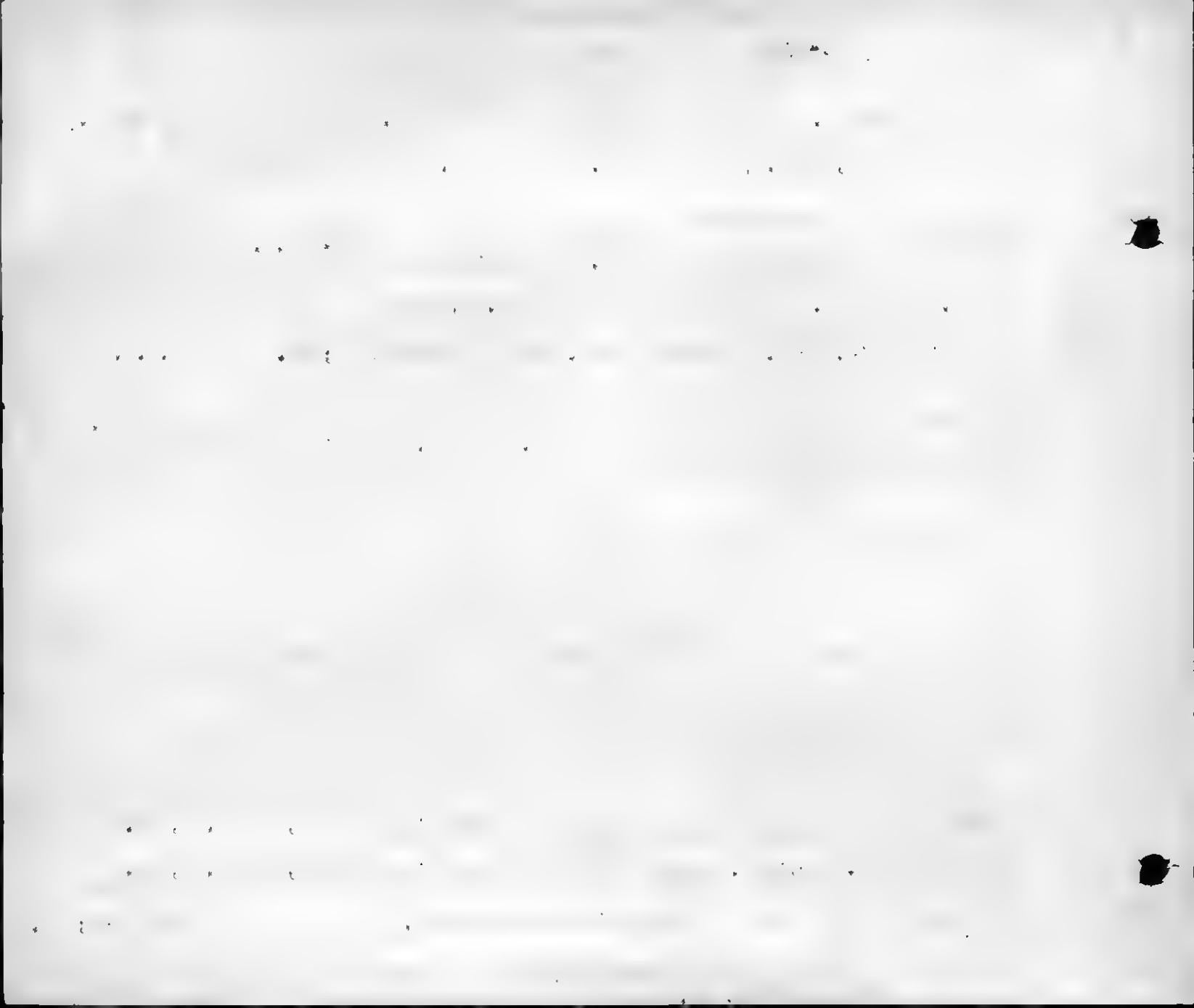
CERTIFICATE OF DEATH

Reg. Dist. No. 668011

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lynn Acres, Balto. 7		c. LENGTH OF STAY IN lb 6 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Balto. 7 (Lynn Acres)		d. STREET ADDRESS 3444 Ripple Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3444 Ripple Road				e. IS RESIDENCE ON A FARM? NO					
3. NAME OF DECEASED (Type or print) William		First	Middle	Last	4. DATE OF DEATH 10.30 P.M.	Month	Day	Year	
					5		31	19 60	
5. SEX M.		6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2, 1870		9. AGE (in years lost birthday) 90		10. IF UNDER 1 YEAR Months Dots Hours Min. 11. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Vice. Pres.		10b. KIND OF BUSINESS OR INDUSTRY Woodbine Nat. Bank		11. BIRTHPLACE (State or foreign country) Carroll Co; Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Edith V. Mullinix		Address Balto. 7 3444 Ripple Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO Acute myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 3 hrs					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH more than 5 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While or work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County)	(State)
21. I certify that I attended the deceased from alive on		May 1955 to 31 May 1960		that I last saw the deceased dead occurred at 11:30 p.m., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 6512 Liberty Road, Balto. 7, Md.		DATE SIGNED Marvin M. Davis	
ACTUAL SIGNATURE Marvin M. Davis		PHYSICIAN'S NAME (Type) Dr. Marvin M. Davis		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Methodist Church Cemetery		22d. LOCATION (City, town, or county) Carroll Co; Md.			
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22f. DATE THEREOF 6/5/60		22g. NAME OF CEMETERY OR CREMATORIAL ADDRESS Methodist Church Cemetery		22h. LOCATION (City, town, or county) Carroll Co; Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers		24a. REC'D BY REGISTRAR DATE JUN 7 '60		24b. REGISTRAR'S SIGNATURE Charles E. Kline					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5528

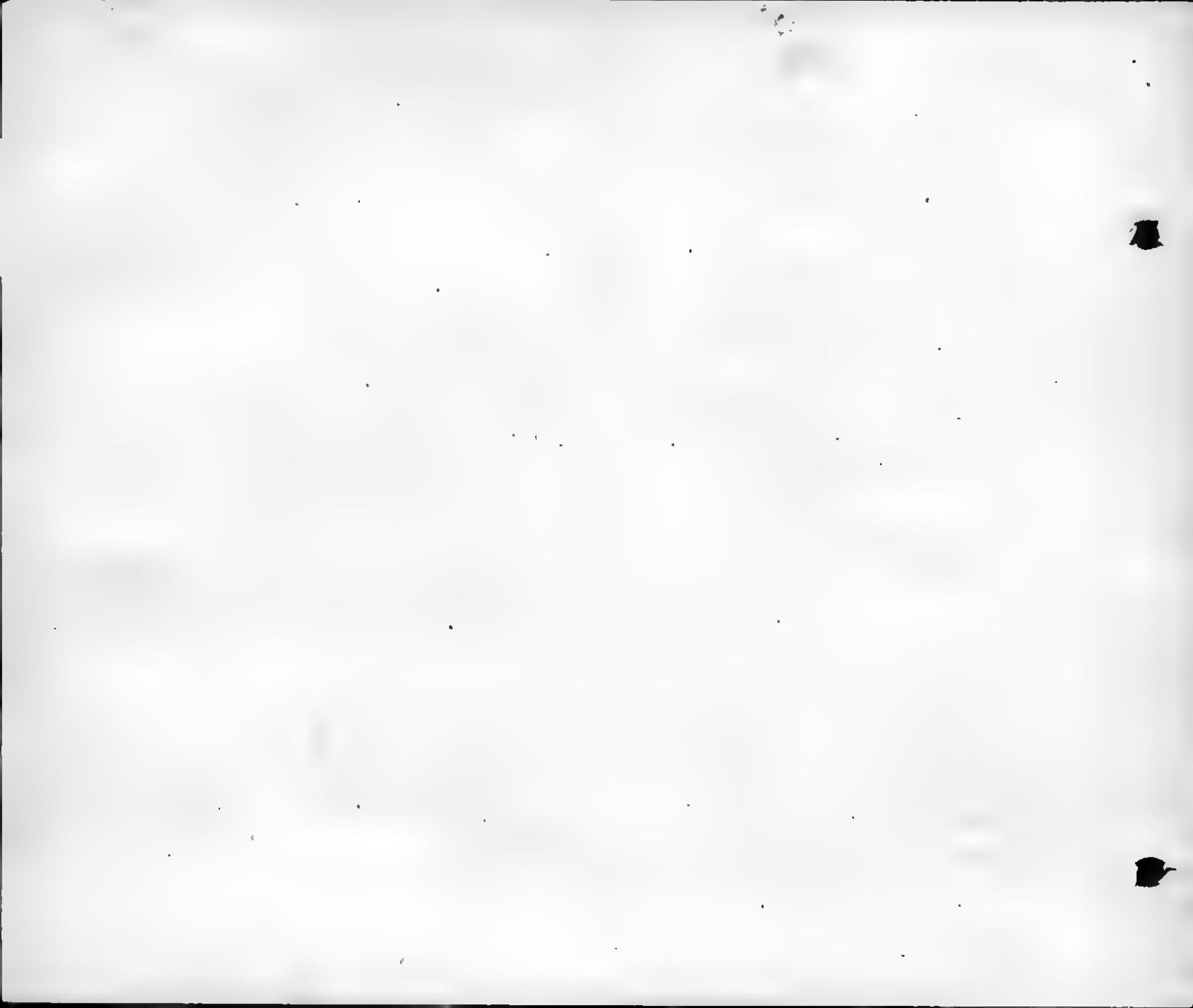
CERTIFICATE OF DEATH

05497
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Milford		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Milford		d. STREET ADDRESS 7217 Rockridge Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7217 Rockridge Road				d. STREET ADDRESS 7217 Rockridge Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MARY	Middle SLEMER	Last MUNCASTER	4. DATE OF DEATH May 18,	Month May	Day 18	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/12/1971	9. AGE (In years last birthday) 88 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Willson			14. MOTHER'S MAIDEN NAME Anna Gilpin				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		INFORMANT Helen Rice-Germantown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (1) - Bronchitis - Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) 2) Arterio Sclerotic Heart Disease (c) 5 yrs. INTERVAL BETWEEN ONSET AND DEATH 4 days.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Partial intestinal obstruction							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Rockville	(County) Md.	(State) Md.
21. I certify that I attended the deceased from <u>May 15, 1960</u> to <u>May 18, 1960</u> that I last saw the deceased alive on <u>May 17, 1960</u> and that death occurred at <u>4108 Liberty Hts. Bldg. - 578-6</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE EARL L. CHAMBERS		ADDRESS (Street, city or town, state) 4108 Liberty Hts. Bldg. - 578-6 DATE SIGNED 5-18-60					
NAME (Type) EARL L. CHAMBERS, M.D.		4108 LIBERTY HEIGHTS AVE.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/20/60	22c. NAME OF CEMETERY OR CREMATORY Rockville		22d. LOCATION (City, town, or county) Rockville, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler		ADDRESS 1331 E. Montgomery Avenue Rockville, Md.	24a. REC'D BY REGISTRAR DATE MAY 20 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5529 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05498

Reg. Dist. No.

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Catonsville

c. LENGTH OF STAY IN lb

3mth12dys

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

SPRING GROVE STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE Maryland

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore

2 11/11

d. STREET ADDRESS

1131 Ridgley Street

e. IS RESIDENCE ON A FARM?

YES NO

3. NAME OF DECEASED (Type or print)

First

Middle

Last

Mary

Nelson

4. DATE OF DEATH

Month Day

Year

January 12 19 60

5. SEX

female

6. COLOR OR RACE

white

7. MARRIED **NEVER MARRIED**

WIDOWED DIVORCED

8. DATE OF BIRTH

January 4, 1880

9. AGE (In years last birthday)

80 yrs.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10b. KIND OF BUSINESS OR INDUSTRY

at Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

union wn

16. SOCIAL SECURITY NO.

unknown

17. INFORMANT

Records: SPRING GROVE STATE HOSPITAL

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

102.0

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Acute Congestive Heart Disease

Progressive

Garder's Varicolar Disease

Fracture left femur

INTERVAL BETWEEN
ONSET AND DEATH

Acute

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

On 12-16-59 open reduction and Smith-Peterson nailing performed at University Hospital

19. WAS AUTOPSY PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING

CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

ON 12-11-59 while at home, patient fell from a low kitchen chair sustaining a frac. of left hip.

20c. TIME OF INJURY Month, Day, Year

Hour a. m. 2 p. m.

12-11-1959

20d. INJURY OCCURRED

While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

home

20f. (City or town)

1131 Ridgley Street

(County)

Baltimore

(State)

Maryland

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and find that death resulted from: Natural causes Accident Suicide Homicide Undetermined cause

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

George M. Kieffer, M. D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

5-12-60

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial 8/16/60

22b. DATE THEREOF

ADDRESS

22d. LOCATION (City, town, or county)

3801 Frederick Ave

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

John J. Cowans Son Hollis

ADDRESS

St.

24a. REC'D BY REGISTRAR

Cathleen S. Thomas

DATE

MAY 16 '60

24b. REGISTRAR'S SIGNATURE

Cathleen S. Thomas



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

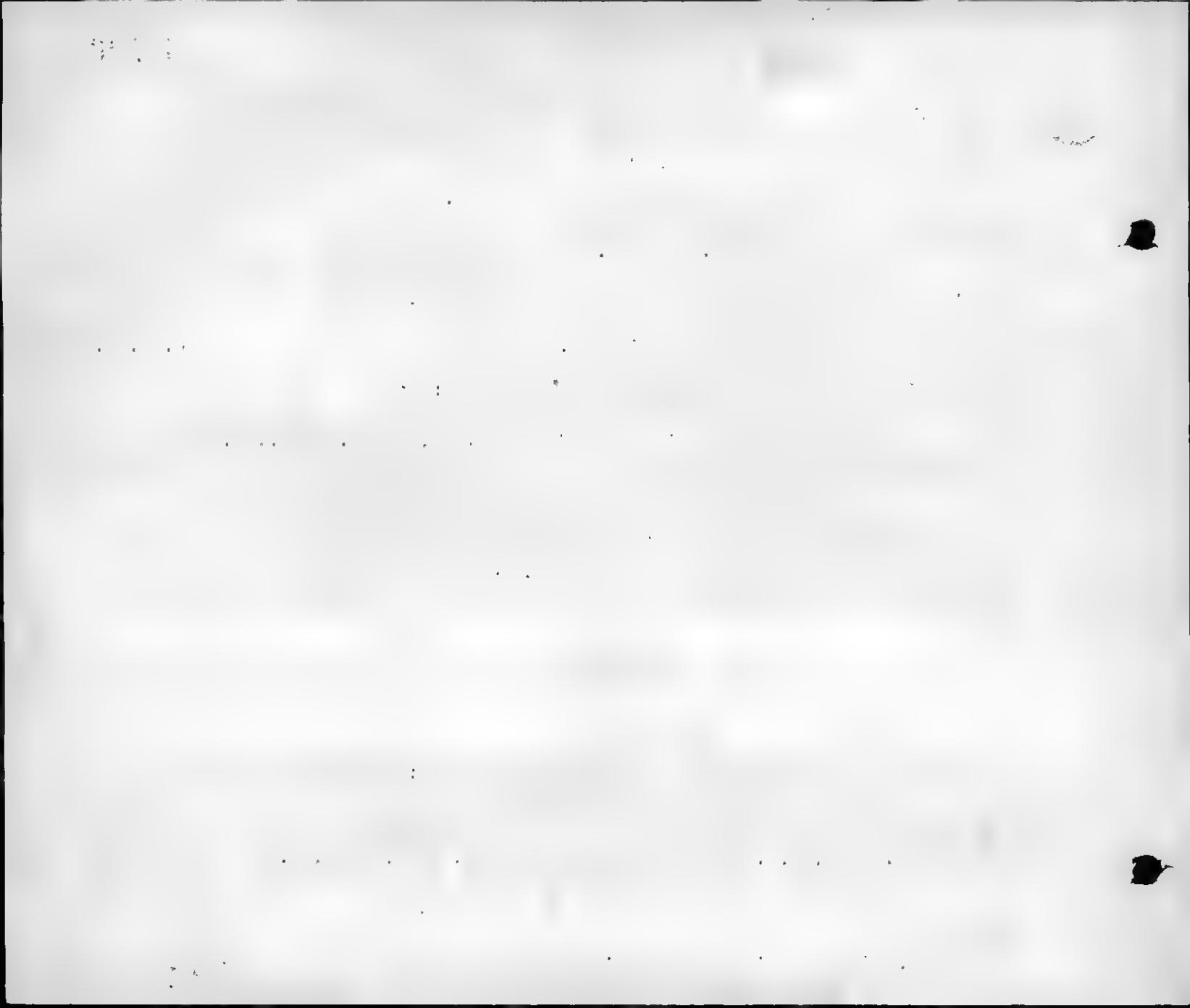
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5530

CERTIFICATE OF DEATH

05499

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 5 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (13)		d. STREET ADDRESS 1625 N. Milton Avenue		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First WILLIAM	Middle E.	Last NORRIS	4. DATE OF DEATH May 23 1960	Month May	Day 23	Year 1960
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 10, 1914	9. AGE (In years less than years 40)	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Automobile Co.		11. BIRTHPLACE (State or foreign country) Whitestone, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Edward Norris				14. MOTHER'S MAIDEN NAME Cora MN: Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown) Yes		16. SOCIAL SECURITY NO WW II		17. INFORMANT Clin/Rec.VAH, BALTO.18,MD.,FT.HOWARD DIVISION		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>EDEMA OF THE LUNGS</u> INTERVAL BETWEEN ONSET AND DEATH 1 DAY 441X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>HYPERTROPHY AND DILATATION OF THE HEART</u> UNKNOWN (c) <u>MALIGNANT NEPHROSCLEROSIS</u> UNKNOWN								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from May 18, 1960, to May 23, 1960, that (2) (we) last saw the deceased alive on May 23, 1960, and that death occurred at 6:15 AM, from the causes and on the date stated above.								
22a. SIGNATURE <u>Thomas R. Hood, M.D.</u>		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/23/60				
22c. PHYSICIAN'S NAME (Type) THOMAS R. HOOD, M.D.		22d. ADDRESS VAH, BALTO.18 MD, FT. HOWARD DIVISION						
23a. BURIAL, CREMATION BURIAL		23b. DATE THEREOF 5-26-60		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cem.		23d. LOCATION (City, town, or county) Baltimore Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE <u>George G. Kelson</u>		ADDRESS Kelson Fun. Home, 1348 N. Calhoun St.		25a. REC'D BY REGISTRAR RAY 24 '60		25b. REGISTRAR'S SIGNATURE <u>Kirby L. Knapp</u>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5531

CERTIFICATE OF DEATH

05500

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Baltimore MARYLAND		Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 53 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pikesville	
3. NAME OF DECEASED (Type or print)		First EARL	Middle Clarence
		Last NOST	4. DATE OF DEATH MAY 1ST 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 7/31/98	9. AGE (in years last birthday) 61 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Master Mariner		10b. KIND OF BUSINESS OR INDUSTRY Shipping Co.	11 BIRTHPLACE (State or foreign country) Baltimore, Maryland
13 FATHER'S NAME Axil Nost		14 MOTHER'S MAIDEN NAME Laura Hammer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO 549-24-8464	17. INFORMANT Clin. Rec. VAH, Balto. 18, Md. Ft. Howard Division
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X PULMONARY EDEMA			
DUE TO ARTERIOSCLEROTIC HEART DISEASE			
Conditions, if any, which gave rise to immediate cause (a), stating the under: (b) ADENOCARCINOMA, PROSTATE			
cause (a), stating the under: (c) METASTATIC ADENOCARCINOMA BONES Prostate HYDRONEPHROSIS, BILATERAL (Due to Adenocarcinoma)			
INTERVAL BETWEEN ONSET AND DEATH RECENT			
UNKNOWN UNKNOWN			
UNKNOWN UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, or item 18.) Adenomata, adrenals, old. Granuloma, left lung, old.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 9, 1960, to May 1, 1960, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 1, 1960, and that death occurred at 7:10PM on the causes and on the date stated above			
22a. SIGNATURE Thomas R. Hood, M.D.		22b. DATE SIGNED 5/2/60	
22c. PHYSICIAN'S NAME (Type) THOMAS R. HOOD, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/4/60	
23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge Cemetery		23d. LOCATION (City, town, or county) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Tickner Funeral Home.		ADDRESS Pennsylvania & North Aves. Baltimore, Maryland	
25a. REC'D BY REGISTRAR DATE MAY 3 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Koenig	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

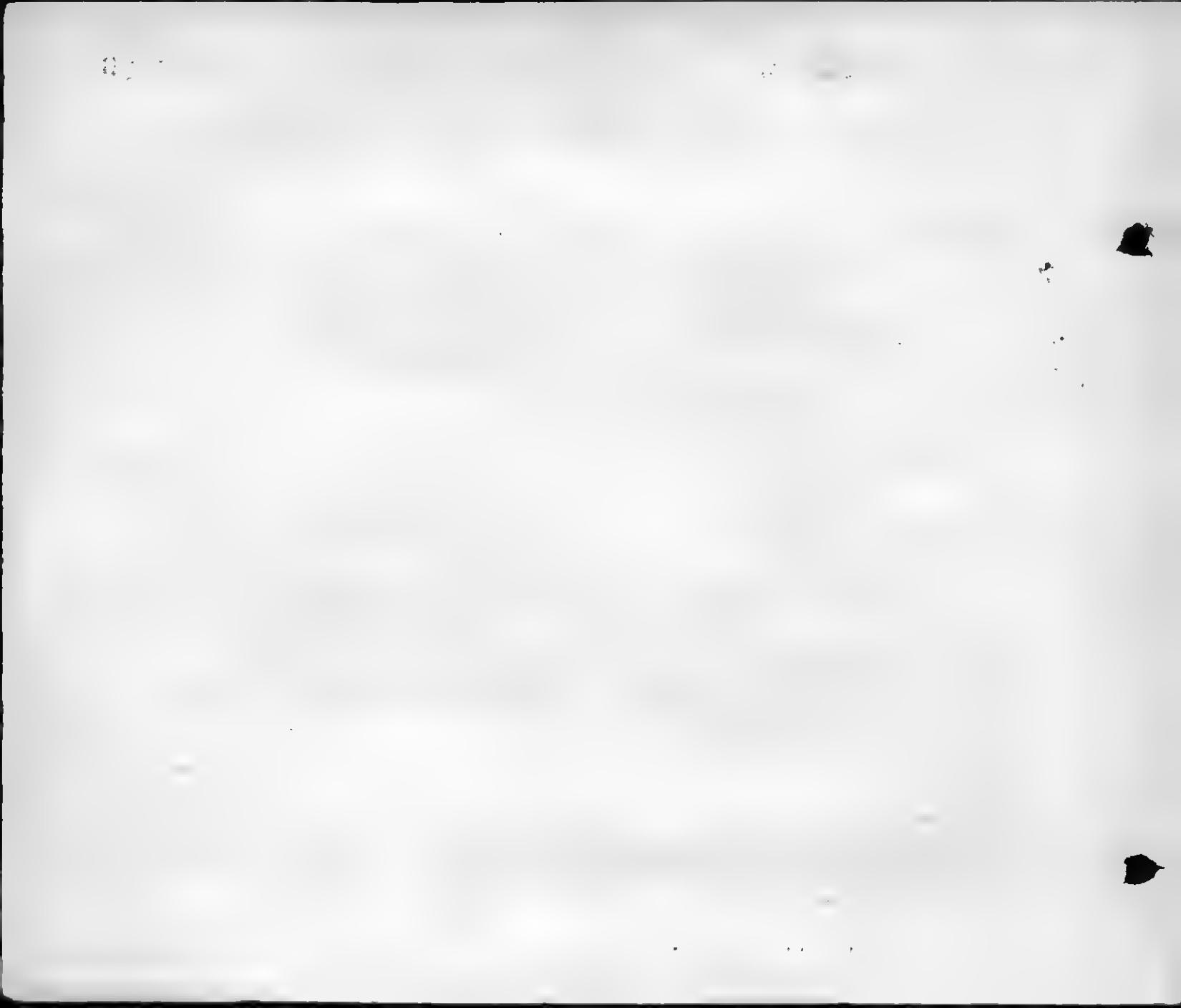
05501
Reg. Dist. No.

5532

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 5 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		e. STREET ADDRESS 4609 YORK ROAD	
3. NAME OF DECEASED (Type or print) GEORGE PHILIP OHLGART		4. DATE OF DEATH Month MAY	Day Year 3 1960
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-1-1872
9. AGE (In years (on birthday) 87 yr.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME WILLIAM OHLGART		14. MOTHER'S MAIDEN NAME ELIZA BETH SCHWAMB	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 215-05-6967	17. INFORMANT Fran L. Smith Jr. Cockeysville, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. Arterios Sclerotic Cardio Vas. disease		DUE TO 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-2 , 19 55 , to 5-2 , 19 60 , that I last saw the deceased alive on 5-2 , 19 60 , and that death occurred at 9:45 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Cockeysville, Md	
ACTUAL SIGNATURE WALTER T. KEEES M.D.		DATE SIGNED 5/3/60	
PHYSICIAN'S NAME (Type) WALTER T. KEEES		COCKEYSVILLE MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-6-60	22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery
22d. LOCATION (City, town, or county) Baltimore		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE MAY 6 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be joined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5533

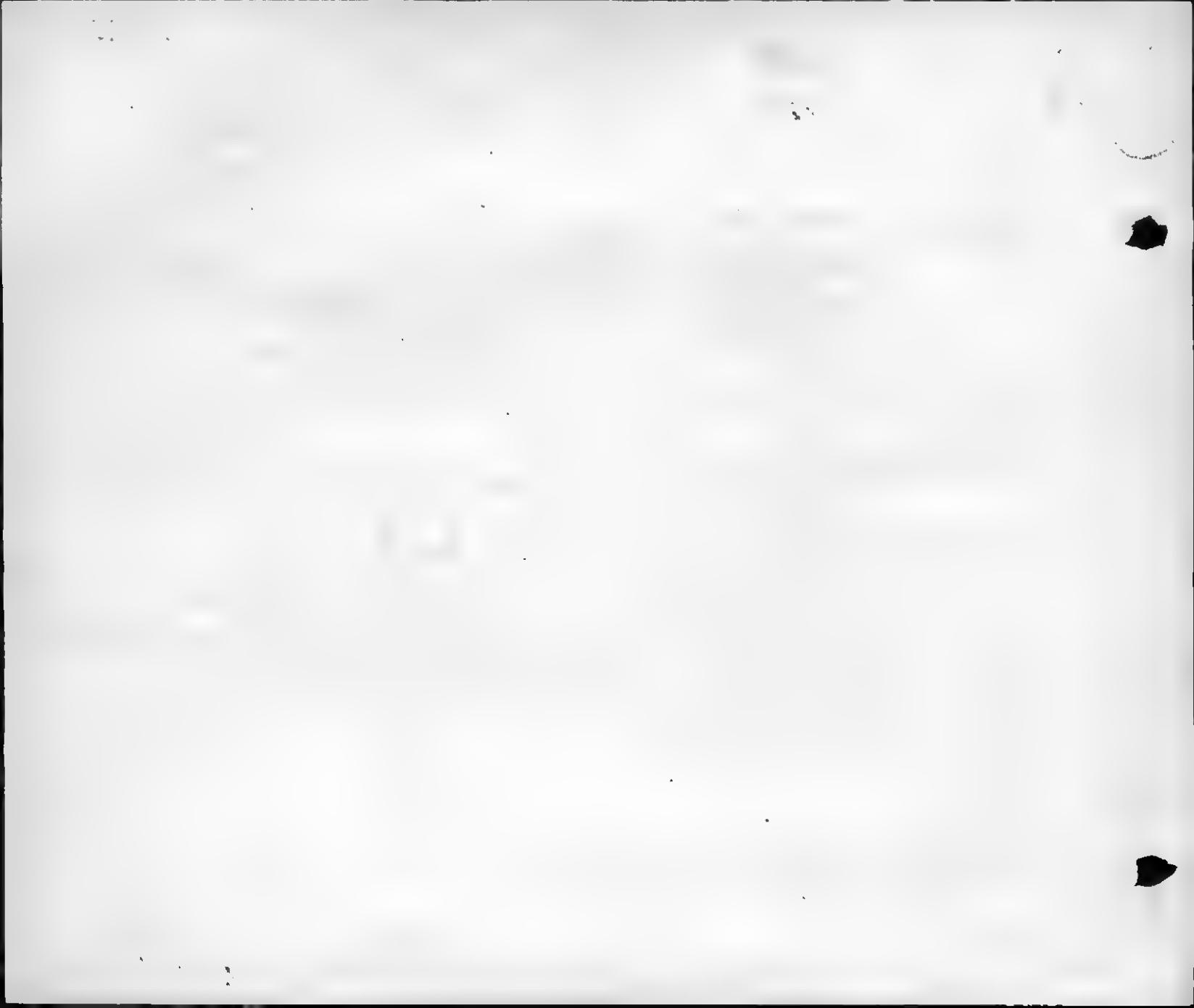
CERTIFICATE OF DEATH

05502

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be joined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>406 Frederick Ave</i>		d. STREET ADDRESS <i>406 Frederick Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Peter G Olson</i>		First <i>Peter</i>	Middle <i>G</i>
4. DATE OF DEATH <i>May 11 1960</i>		Month <i>May</i>	Day <i>11</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>12/13/77</i>		9. AGE (In years last birthday) <i>82 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Detroit L.R. Telephone Co</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Michigan</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Ole Olson</i>		14. MOTHER'S MAIDEN NAME <i>Emma Olson</i>	Address <i>— Mrs. Rachel Olson</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>—</i>	17. INFORMANT <i>— Mrs. Rachel Olson</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>① Chronic Brain Syndrome with</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>② Associated Arteriosclerosis.</i> (b) <i>② Degenerative Heart Disease</i> DUE TO (c) <i>—</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>—</i>	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <i>1956 5/11/60</i>	20f. (City or town) (County) <i>5/11/60</i> (State) <i>—</i>
21. I certify that (I) (this hospital) attended the deceased from <i>5/10/60</i> to <i>5/11/60</i> , that (I) (we) last saw the deceased alive on <i>5/10/60</i> , and that death occurred at <i>11:45 A.M.</i> from the causes and on the date stated above		22a. SIGNATURE <i>W.E. McGrath MD</i>	
22c. PHYSICIAN'S NAME (Type) <i>W.E. McGrath</i>		22b. DATE SIGNED <i>5/12/60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>5/14/60</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Woodlawn</i>	23d. LOCATION (City, town, or county) <i>Baltimore</i> (State) <i>Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>McGrath & Son</i>		ADDRESS <i>28</i>	25a. REG'D BY REGISTRAR DATE <i>May 12 60</i>
			25b. REGISTRAR'S SIGNATURE <i>Arthur S. Chase</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 film G263 5-14-60 et

5534

CERTIFICATE OF DEATH

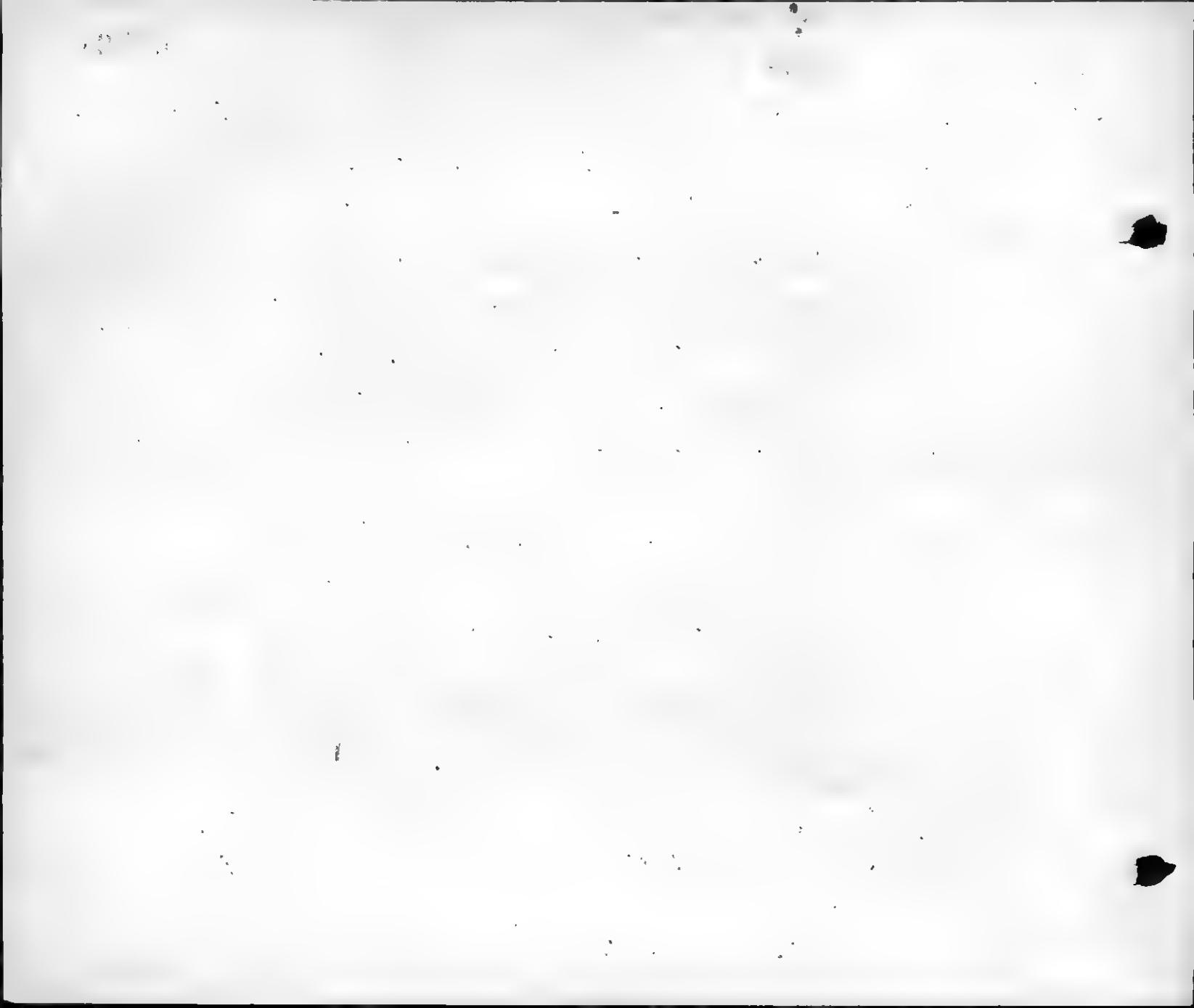
05503

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MD		b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 3 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		d. STREET ADDRESS 1920 Yanderwood Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 920 Yanderwood Rd.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John		First	Middle	Last	4. DATE OF DEATH Month MAY	Day 14	Year 1960
5. SEX MALE		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH JUNE 3 1925	9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce Buyer		10b. KIND OF BUSINESS OR INDUSTRY Produce		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anthony Palmisano		14. MOTHER'S MAIDEN NAME Josephine (last name unknown)				Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 219-58-1853		INFORMANT Dorothy Palmisano 920 Yanderwood Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 14X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Cardiac - Respiratory failure (c) DUE TO Cardiac arrhythmia (d) DUE TO Rheumatic Endocarditis						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Mitral Valvular Disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 14 April 1960					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 14605 Edmondson		20f. (City or town) (County) (State) Baltimore 29, Md.	
21. I certify that I attended the deceased from 14 April , 1960, to 14 May , 1960, that I last saw the deceased alive on 14 May , 1960, and that death occurred at 1:20 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town; state) 14605 Edmondson		DATE SIGNED 14 May 60	
ACTUAL SIGNATURE William J. Bryson		M.D.					
PHYSICIAN'S NAME (Type) William J. Bryson							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 5-17-60		22b. DATE THEREOF 5-17-60		22c. NAME OF CEMETERY OR CREMATORIAL Loydon Park		22d. LOCATION (City, town, or county) (State) BALTIMORE MD.	
23. FUNERAL DIRECTOR'S SIGNATURE C. G. L. Schuyler		ADDRESS 616 Governor St. Francis Dr., Suite 2101 Frederick Ave.		24a. REC'D BY REGISTRAR DATE MAY 16 '60		24b. REGISTRAR'S SIGNATURE Clifford S. Krause	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05504

5535		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
1. PLACE OF DEATH o. COUNTY Baltimore		o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 59 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First FRANK		Middle M. PANOWICZ	
Last PANOWICZ		Month May	Day 6
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1915	
WIDOWED <input type="checkbox"/>		9. AGE (in years last birthday) 45 yrs.	
DIVORCED <input type="checkbox"/>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Drawbridge Operator		10b. KIND OF BUSINESS OR INDUSTRY City Bridges	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John S. Panowicz		14. MOTHER'S MAIDEN NAME Mary Roszyk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-07-4408	
17. INFORMANT Clin. Rec. VAH, Balto. 18, Md. Ft. Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		19. INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ANAPLASTIC CARCINOMA, LEFT LUNG		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VAH (this hospital) attended the deceased from March 8, 1960 to May 6, 1960 , that VAH (we) last saw the deceased alive on May 6, 1960 , and that death occurred at 10:15 AM from the causes and on the date stated above.		22b. DATE 5/6/60	
22a. SIGNATURE <i>Thomas R. Hood</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	
22b. PHYSICIAN'S NAME (Type) THOMAS R. HOOD, M.D.		22d. ADDRESS VAH, BALTO. 18, MD. FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/10/60	
23c. NAME OF CEMETERY OR CREMATORIAL Saint Stanislaus Cemetery Baltimore		23d. LOCATION (City, town, or county) (State) 22, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Fred W. Ozazewski		25a. ADDRESS 1930 Eastern Ave.	
		25a. REC'D BY REGISTRAR MAY 10 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5536

CERTIFICATE OF DEATH

05505

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 231 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 4714 Pimlico Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First AUGUST	Middle L.	Last PARKER	4. DATE OF DEATH	Month May	Day 27	Year 1960
S SEX Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH September 17, 1891	9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Bakery		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Frederick Parker				14. MOTHER'S MAIDEN NAME Mary Sophie Sang				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-07-9809		17. INFORMANT Clin. Records VAH, Balto. Md. Ft. Howard Div.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EDEMA								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) CARCINOMA OF THE PANCREAS WITH METASTASIS TO THE UNKNOWN (c) LIVER, LUNGS AND ADRENAL GLANDS								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) Baltimore (County) Md. (State)		
21. I certify that Harold R. Johnson attended the deceased from October 9, 1959 to May 27, 1960 , that we last met on October 9, 1959 and that death occurred at 4:55 PM from the causes and on the date stated above								
22a. SIGNATURE Harold R. Johnson		22b. DATE SIGNED 5/28/60						
22c. PHYSICIAN'S NAME (Type) HAROLD R. JOHNSON, M.D.		22d. ADDRESS VAH, BALTO. MD. FT HOWARD DIVISION 5/28/60						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-31-60		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		23d. LOCATION (City, town, or county) Baltimore, Md. (State)		
24. FUNERAL DIRECTOR'S SIGNATURE John Cook Blight, Inc.		ADDRESS 6009 Harford Rd.		25a. REC'D BY REGISTRAR JUN 1 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Krause		
25. COOK BLIGHT FUNERAL HOME, 6009 Harford Rd., Balto. Md.								



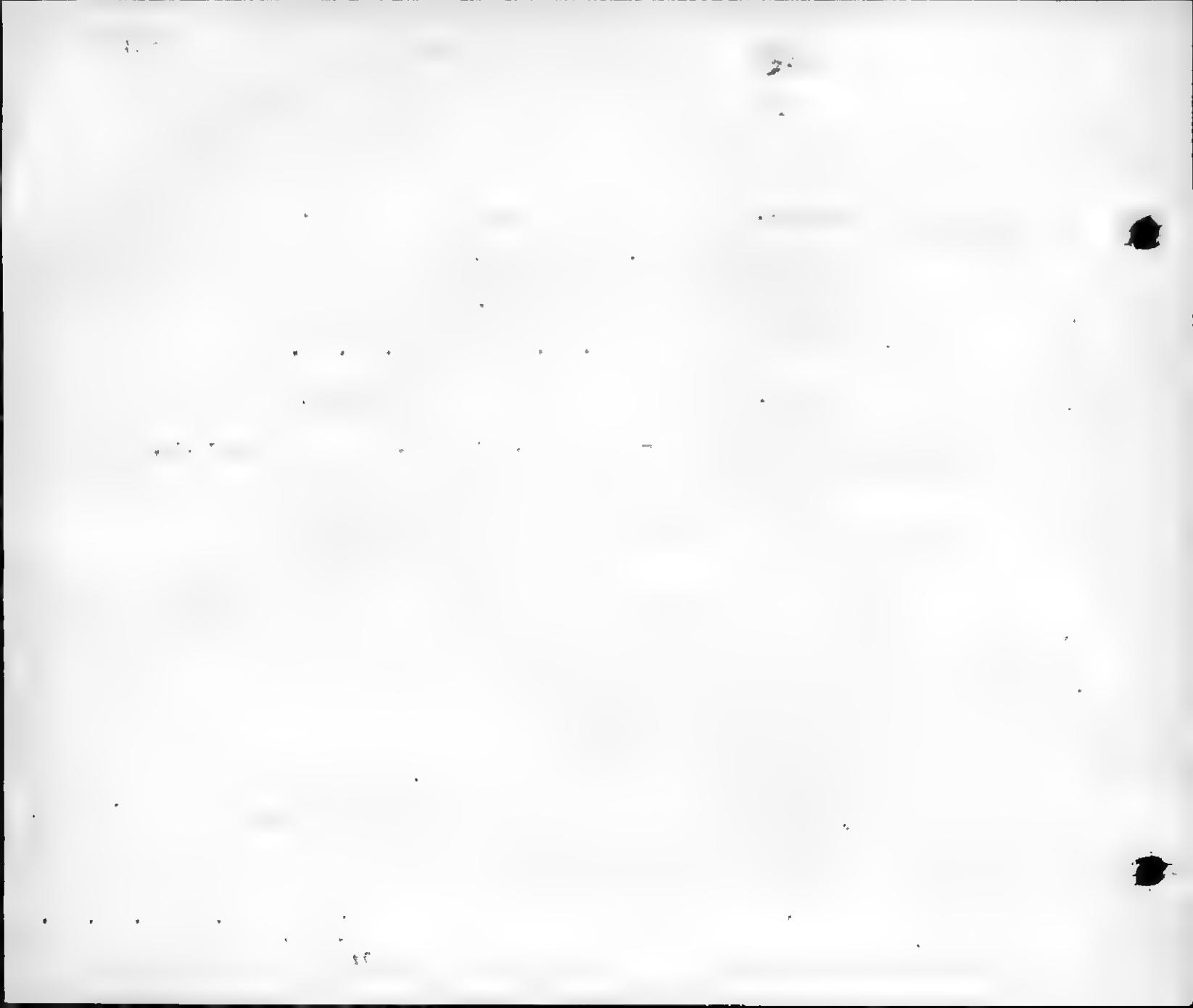
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5537 CERTIFICATE OF DEATH

05506

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 Henry Ave.		d. STREET ADDRESS 5 Henry Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Frederick	Middle Q.	Last Pensel
4. DATE OF DEATH May 5, 1960	Month May	Day 5	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1895
9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman-retired		10b. KIND OF BUSINESS OR INDUSTRY Gas & Elec. Co.	
11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John B. Pensel		14. MOTHER'S MAIDEN NAME Annie Knight	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-07-6105	
17. INFORMANT Mrs. Nettie A. Pensel		Address 5 Henry Ave. 6	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Atherosclerotic Cardiovascular Disease			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-29, 1957, to 5-5, 1960, that I last saw the deceased alive on 4-20-60, 1960, and that death occurred at 3 pm, from the causes and on the date stated above.			
ACTUAL SIGNATURE John C. Hyde		ADDRESS (Street, city or town, state) 7527 Belair Rd.	
PHYSICIAN'S NAME (Type) JOHN C. Hyde		DATE SIGNED 5-6-60	
22a. BUR. AL. CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 9, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Gardens Of Faith	22d. LOCATION (City, town, or county) (State) Trump Mill Rd. Balto. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home	ADDRESS 7401 Belair Rd.	24a. REC'D BY REGISTRAR MAY 11 1960	24b. REGISTRAR'S SIGNATURE Sewing & Sons



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5538

05507

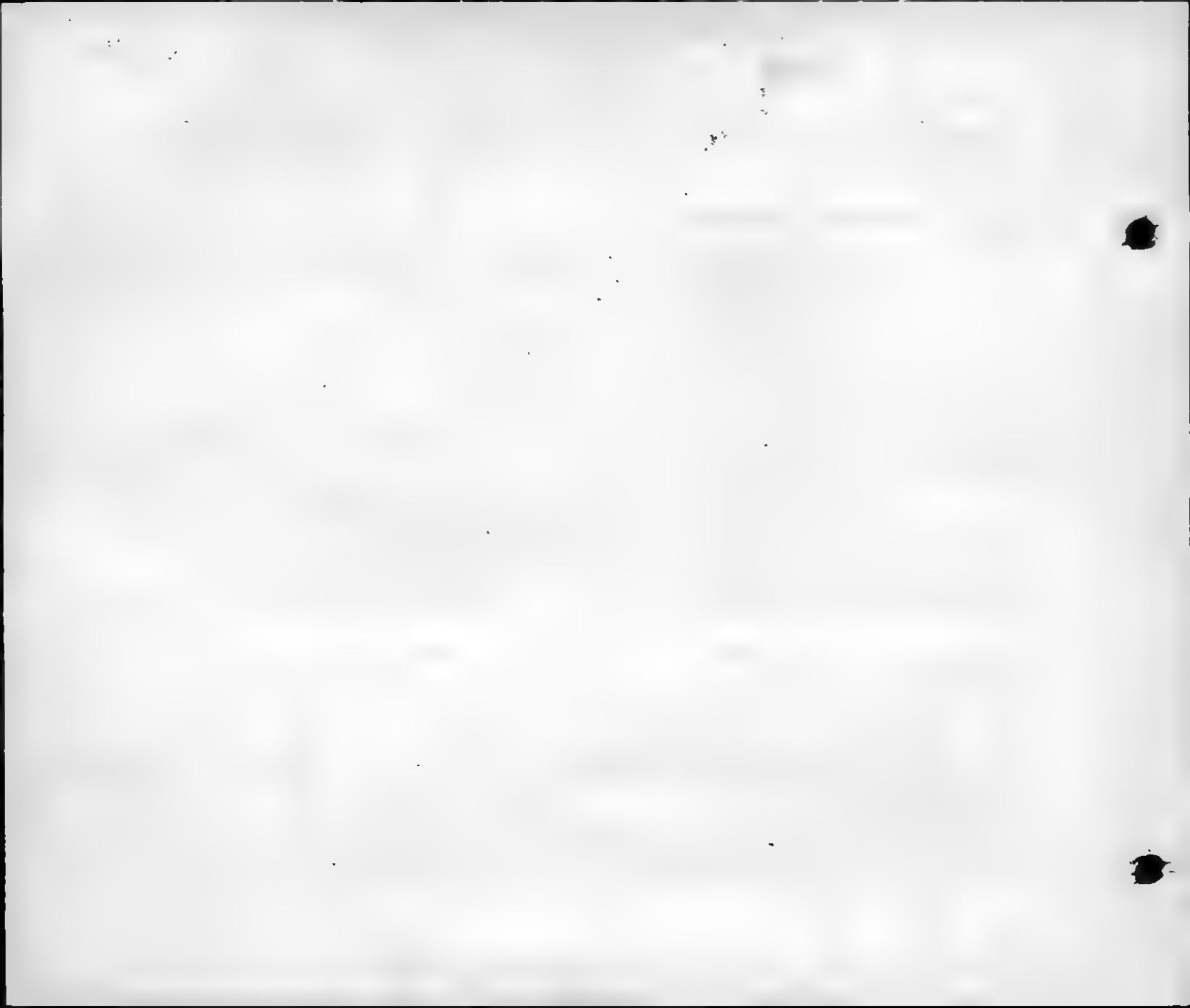
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>			c. LENGTH OF STAY IN 1b c. STREET ADDRESS <i>115 Smithwood Ave</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>115 Smithwood Ave</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>John H. Pepples</i>			First <i>J</i>	Middle <i>H</i>	Last <i>Pepples</i>
4. DATE OF DEATH Month <i>May</i>	Day <i>3</i>	Year <i>1960</i>	5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <i>7/12/196</i>
8. WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) <i>63 yrs</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Baltimore Transit Co</i>	12. BIRTHPLACE (State or foreign country) <i>Med.</i>
13. FATHER'S NAME <i>John H. (Dr.)</i>			14. MOTHER'S MAIDEN NAME <i>Magel</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>215-10-3935</i>		
17. INFORMANT <i>Wife Lynes T. Pepples</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Ac. coronary occlusion</i> DUE TO <i>Coronary Insufficiency</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized arteriosclerosis</i> DUE TO <i>Generalized arteriosclerosis</i> (c) <i>Generalized arteriosclerosis</i>		
19. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>Baltimore</i> (County) <i>Md</i> (State) <i>Md</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>April 28, 1960</i> to <i>May 3, 1960</i> , that (I) (we) last saw the deceased alive on <i>May 2, 1960</i> , and that death occurred at <i>2 AM</i> , from the causes and on the date stated above.					
22a. SIGNATURE <i>Justinas Prudka</i>			22b. DATE SIGNED <i>28 May 1960</i>		
22c. PHYSICIAN'S NAME (Type) <i>Justinas Prudka</i>			22d. ADDRESS <i>1707 Edmonson Ave Baltimore 28 Md</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/6/60</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Cathedral</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>M. Prudka & Son</i>			25a. ADDRESS <i>28</i>		
25b. REC'D. BY REGISTRAR <i>May 6 '60</i>			25c. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		

4

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed.

VR A15 {4}
15M 9/59



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
 may be signed by the hospital or attending physician and completely filled in by the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

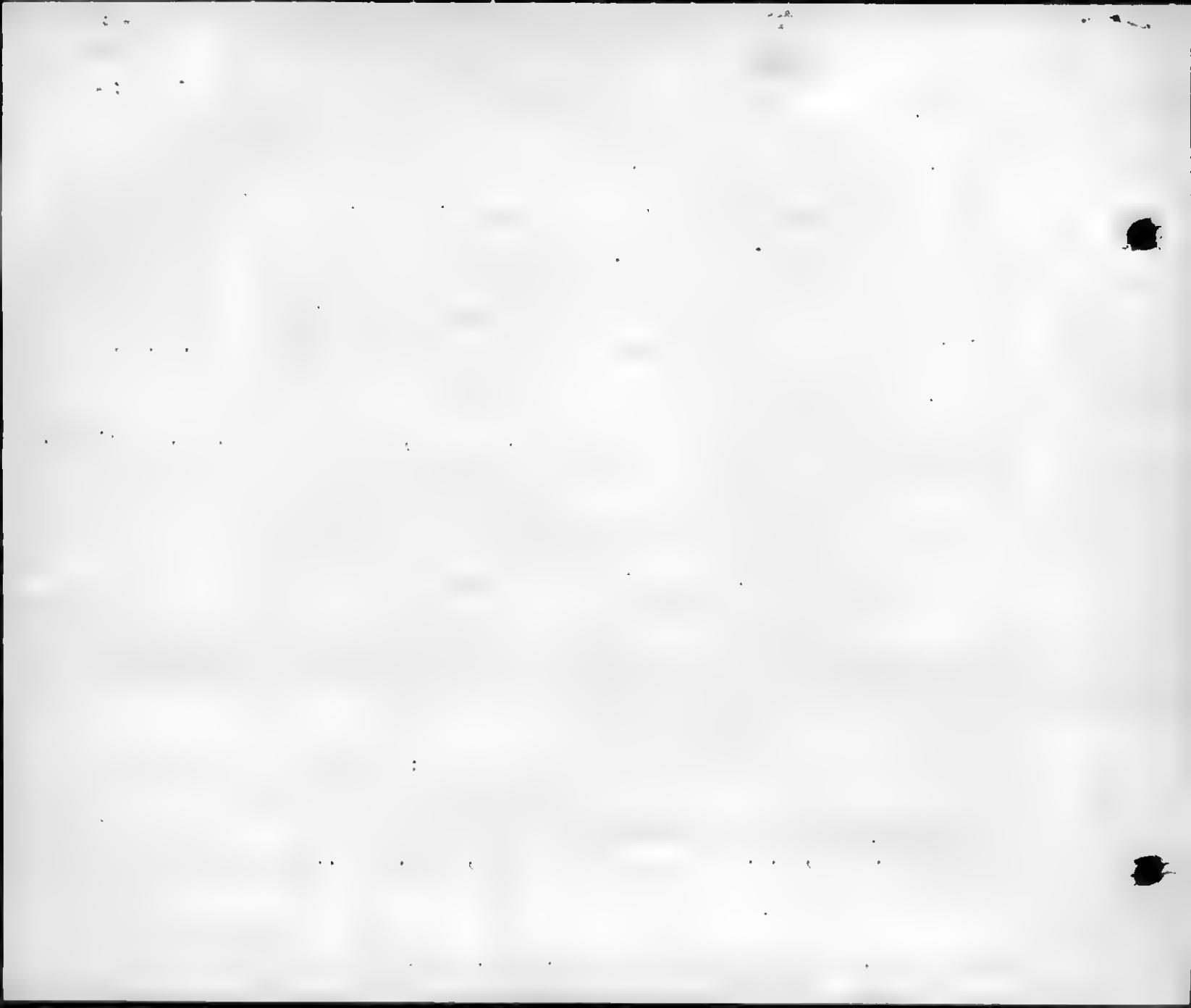
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5539

CERTIFICATE OF DEATH

05508

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 2532 Madison Avenue (17)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First GEORGE	Middle E.	Last PHILLIPS	4. DATE OF DEATH	Month May	Day 25	Year 1960
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH June 2, 1900	9. AGE (in years last birthday) 59	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Stamping Clerk		10b. KIND OF BUSINESS OR INDUSTRY Drug Store		11. BIRTHPLACE (State or foreign country) Pocomoke City, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John T. Phillips				14. MOTHER'S MAIDEN NAME Margaret Jenkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO Yes WW II 212-22-2104		17. INFORMANT Clin. Rec., VAH, Baltimore 18, Md., Ft. Howard Div.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c) HYPERTENSIVE VASCULAR DISEASE DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 23, 1960, to May 25, 1960, that (I/we) last saw the deceased alive on May 25, 1960, and that death occurred at _____ M., from the causes and on the date stated above.							
22a. SIGNATURE Thomas R. Hood, M.D.				22b. DATE 5/25/60			
22c. PHYSICIAN NAME THOMAS R. HOOD, M.D.		M.D. ATTENDING PHYS <input type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS <input checked="" type="checkbox"/>	
22d. ADDRESS VAH, BALTO. 18, MD., FORT HOWARD DIVISION							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/28/60		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		23d. LOCATION (City, town, or county) Baltimore (State) 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips 1808 N. Monroe St. Balto. 17, MD.				25a. REC'D BY REGISTRAR MAY 31 '60		25b. REGISTRAR'S SIGNATURE Charles S. Knott	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5540

CERTIFICATE OF DEATH

05509

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

BALTIMORE MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

ENGLISH CONSUL

c. LENGTH OF STAY IN 1b

4 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

a. STATE MD

b. COUNTY BALTIMORE

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

3018 Alabama Ave

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

ENGLISH CONSUL

d. STREET ADDRESS

3018 Alabama Ave

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (in years
last birthday)

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.
Months Days Hours Min

FEMALE

White

WIDOWED DIVORCED

13 March 1884

76

yrs

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

TAILOR (SET)

10b. KIND OF BUSINESS OR INDUSTRY

Clothing (whl)

11. BIRTHPLACE (State or foreign country)

Austria Hungary

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Kosta Vukovac

14. MOTHER'S MAIDEN NAME

Catherine

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

NO

(If yes, give war or date of service)

16. SOCIAL SECURITY NO.

X-01-8809

17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

153.4

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

DUE TO

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

124 days

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.20d. INJURY OCCURRED
While at work Not while at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Feb 1960 to May 4, 1960, that I last saw the deceased
alive on May 4, 1960, and that death occurred at 3 P. M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

M.D.

PHYSICIAN'S
NAME (Type)

PAUL SCHNITZL

22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial 22b. DATE THEREOF
11 May 1960 22c. NAME OF CEMETERY OR CREMATORIUM
Hudon Park Cem 22d. LOCATION (City, town, or county)
19 ALTO MD (State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS
KFC Walters Bros. Stricklers24a. REC'D BY REGISTRAR
MAY 10 '60
DATE24b. REGISTRAR'S SIGNATURE
C. S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05510

5541

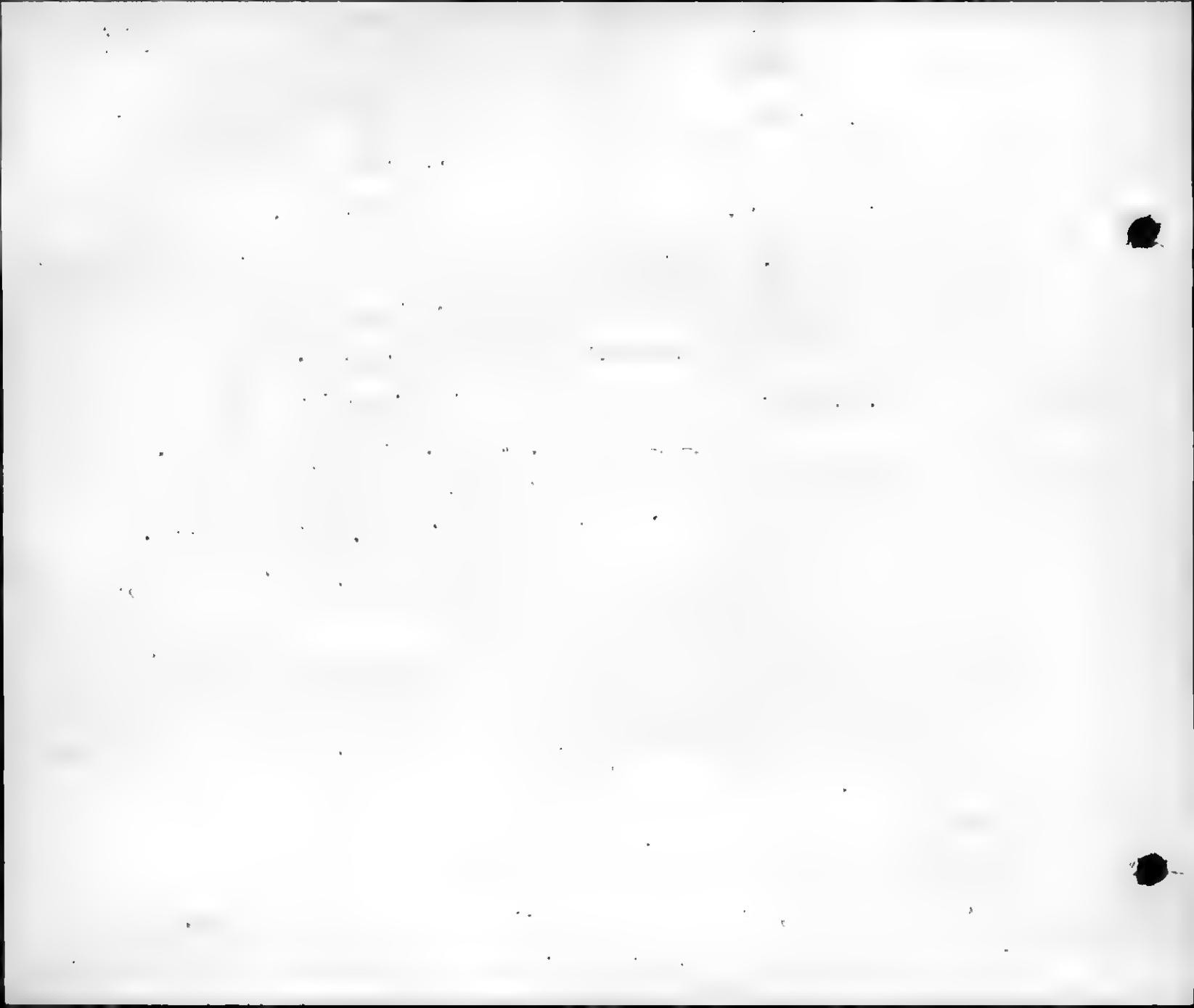
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton		c. LENGTH OF STAY IN 1b Fullerton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8313 Belair Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Wm. Andrew	First	Middle	Last
4. DATE OF DEATH May 26, 1960	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1914
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor	10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) Baltimore, Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Wm. A. Potts		14. MOTHER'S MAIDEN NAME Emma Krumholtz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-11-3668	
17. INFORMANT Mrs. Marie C. Potts 8313 Belair Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>620-1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
<i>Coronary Sclerosis</i> <i>Myocardial Hypertension</i> <i>Coronary Thrombosis & Occlusion</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5/21/60</i> to <i>5/26/60</i> , that I last saw the deceased alive on <i>5/26/60</i> , and that death occurred at <i>5</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>F. Fred. Ruzic, M.D.</i>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>F. Fred. Ruzic, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 30, 1960	
22c. NAME OF CEMETERY OR CREMATORIAL London Park		22d. LOCATION (City, town, or county) Baltimore, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gassahn Funeral Home, 7401 Belair Road #6.</i>		24a. REC'D BY REGISTRAR DATE MAY 31 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



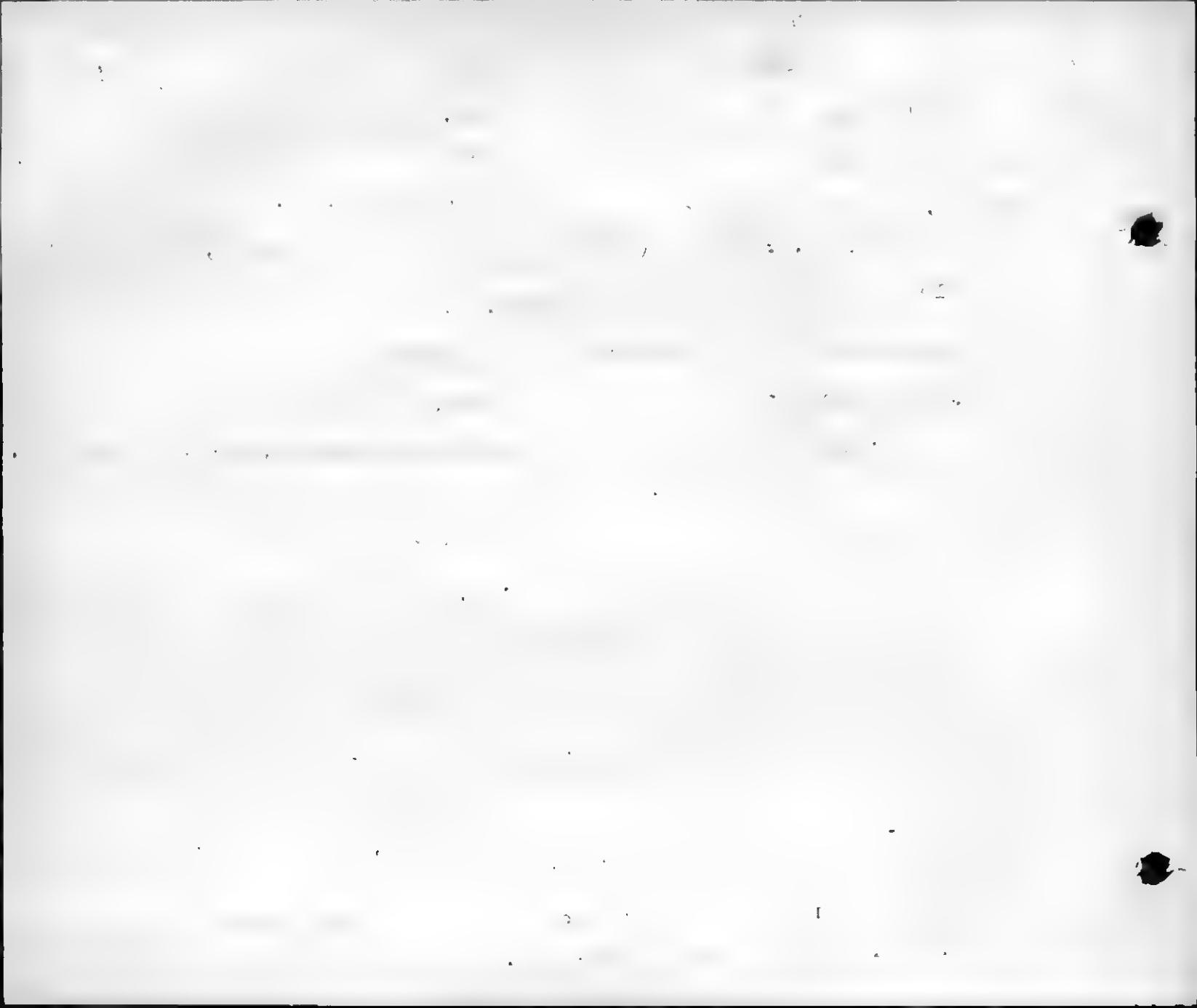
1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 12 & 14 Film G262 5/11/60 iwk 05511

5542 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 1 month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Wasil L. Prihodich (Also Prigidich)		4. DATE OF DEATH Month Day Year May 3, 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1894
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stevedore		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Russia ✓	
13. FATHER'S NAME Wasil Prihodich		14. MOTHER'S MAIDEN NAME Mary unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. 216-07-7555	
17. INFORMANT Anastasia Prihodich, 2320 Jefferson St.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO Pulmonary Edema 3 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO Cardiac failure 3 hrs			
(c) Congestive heart disease		DUE TO Edema	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Concussion of the esophagus	
20c. TIME OF INJURY Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore (County) Md. (State) Md.	
21. I certify that I attended the deceased from 4/2 to 5/3 , 1960, that I last saw the deceased alive on 5/3/60 , 1960, and that death occurred at 1 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 4405 EDMONDSON AVE BALTIMORE 29 MD DATE SIGNED Cliff Ratliff, Jr. M.D.	
ACTUAL DEATH DATE		PHYSICIAN'S NAME (Type) CLIFF RATLIFF, JR. BALTIMORE 29 MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/6/60	
22c. NAME OF CEMETERY OR CREMATORIAL Lorraine		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Ave.		24a. REC'D BY REGISTRAR DATE MAY 6 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thorne	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5543

CERTIFICATE OF DEATH

05512
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
<i>Baltimore</i>		MARYLAND <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
<i>Hanover Towson</i>		<i>Hanover Towson</i>	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS	
<i>1856 Edgewood Road</i>		<i>1856 Edgewood Rd</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Adam Lauer</i>			
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Adam</i>		<i>Lauer</i>	<i>La</i>
4. DATE OF DEATH		Month	Day
		5	22
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
<i>Male</i>		<i>white</i>	<i>5-11-1891</i>
9. AGE (in years last birthday) yrs		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days
<i>69</i>			
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>Retired</i>		<i>Produce</i>	<i>Baltimore Md</i>
12. CITIZEN OF WHAT COUNTRY?		<i>U.S.A</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Augustas Gustav</i>		<i>Monica</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO	INFORMANT Address <i>Eva Lauer - home</i>
		<i>219-320408</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		18. INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Brain Hemorrhage, Recurrent</i> 8 hrs	
260X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) <i>Diabetes Mellitus</i> 8 1/2 yrs	
		DUE TO (c) <i>Arterio Sclerosis</i> 8 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Chronic Coronary Insufficiency and Cardiac Atrial fibrillation</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>5/22/60</i> , 19, to <i>5/23/60</i> , 19, that I last saw the deceased alive on <i>5/22/60</i> , 19, and that death occurred at <i>119</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>5138 Lewis Ave, Towson 4 Md</i>		22. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> <i>5-25-60</i>	
		22c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore National</i>	22d. LOCATION (City, town, or county) <i>Baltimore Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis Inc 2100 Eutaw Pl</i>		24a. ADDRESS <i>5138 Lewis Ave 2100 Eutaw Pl</i>	24b. REC'D BY REGISTRAR DATE <i>MAY 24 '60</i>
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

TO HOS. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
 may be signed by the hospital or attending physician.

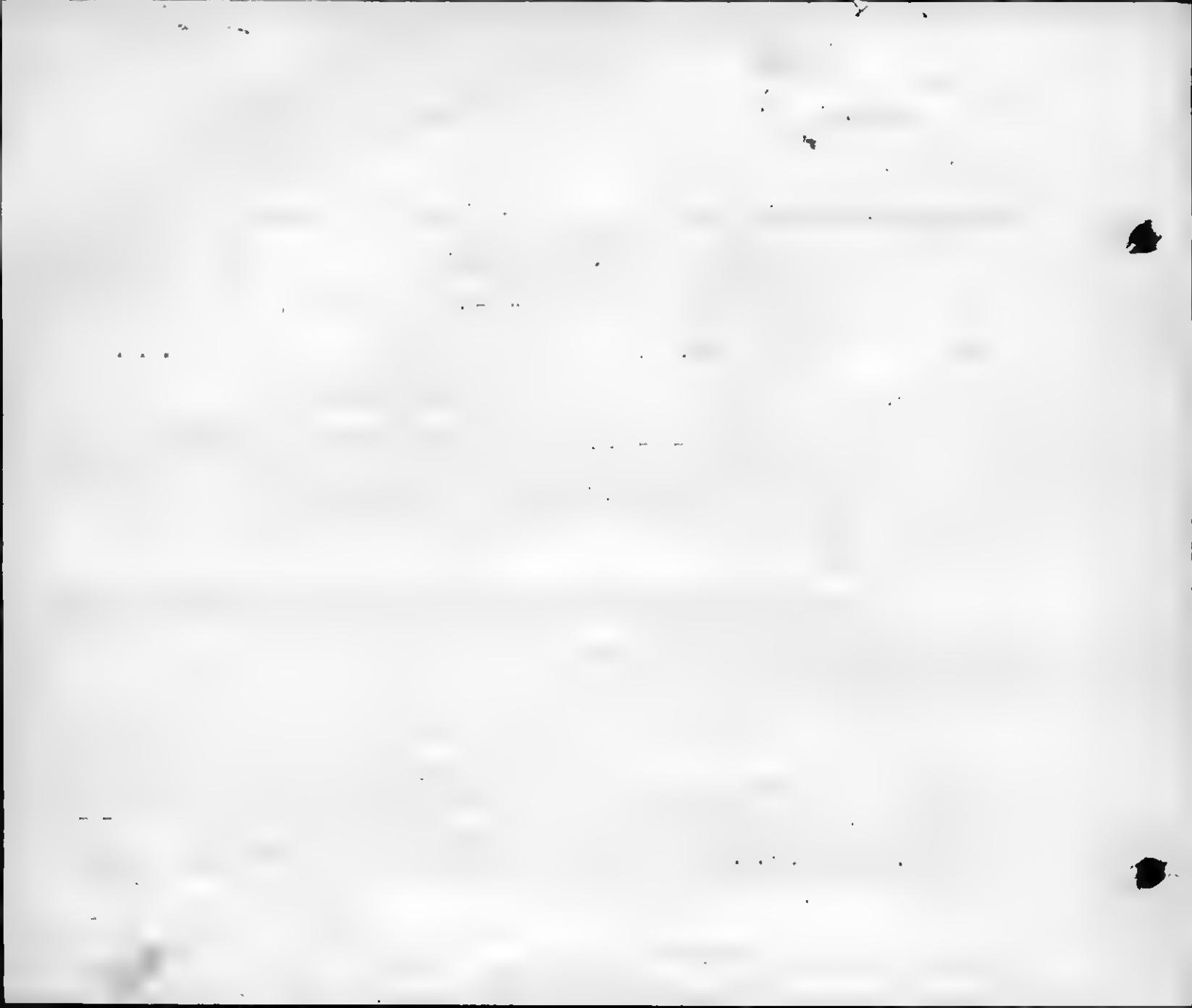
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE MARYLAND	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 8 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	Firs EDWARD	Middle E.	Last RENZ
4. DATE OF DEATH MAY	Month MAY	Day 8	Year 1960
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9-15-92
9. AGE (In years last birthday) 67	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK	11. KIND OF BUSINESS OR INDUSTRY BREWERY	12. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME GERHARD RENZ	14. MOTHER'S MAIDEN NAME EMMA SCHUDENBERG	15. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES	17. SOCIAL SECURITY NO. 217-16-7221	18. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION	Address
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS (SITE OF PRIMARY UNKNOWN)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from April 30 1960 to May 8 1960 that (I) (we) last saw the deceased alive on May 8 1960 and that death occurred 9:20 pm from the causes and on the date stated above.			
22a. SIGNATURE <i>John D. Talbert, M.D.</i>		M.D. <input type="checkbox"/> ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED 5-9-60
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.			
23a BURIAL CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF 5/13/60	23c NAME OF CEMETERY OR CREMATORIAL LOUDON PARK
23d LOCATION (City, town, or county) BALTIMORE MARYLAND		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard Ruck Funeral Home-5305 Harford Rd		25a. ADDRESS Baltimore Md	25b. REC'D BY REGISTRAR DATE MAY 11 '60
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Knapp</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

85514

5545

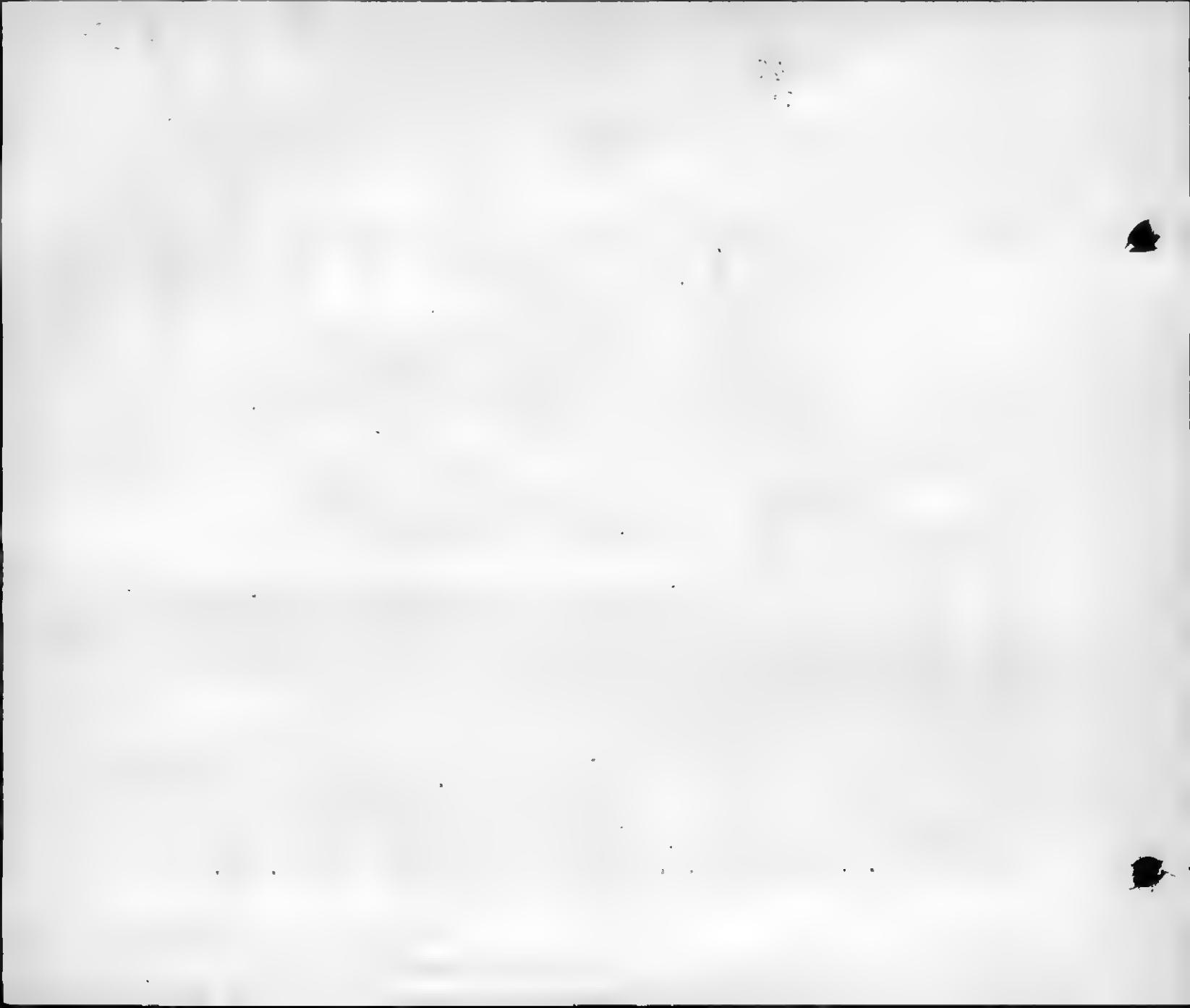
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <i>6108 Old Frederick Rd.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6108 Old Frederick Rd.</i>		d. STREET ADDRESS <i>6108 Old Frederick Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>Edna Estelle Ringgold</i>		First <i>Edna</i>	Middle <i>Estelle</i>
3. NAME OF DECEASED (Type or print) <i>Edna Estelle Ringgold</i>		4. DATE OF DEATH Month <i>May</i>	Day <i>24</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>NEGRO</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <i>5-12-1900</i>
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <i>5-12-1900</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <i>5-12-1900</i>	9. AGE (In years last birthday) <i>60 yrs</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Md.</i>
12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i>		13. FATHER'S NAME <i>Edward Matthews</i>	14. MOTHER'S MAIDEN NAME <i>Daisy Jackson</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>(If yes, give war or date of service)</i>	17. INFORMANT <i>Henry Ringgold</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 Hour</i>	
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</i>		DUE TO <i>Mitral Insufficiency</i>	
(b)		DUE TO <i>Hypertensive Cardiac Disease</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>57 Winters Lane</i>
20f. (City or town) <i>(County)</i> (State) <i>M.D.</i>			
21. I certify that I attended the deceased from <i>Jan. 15th 1958</i> to <i>May 24th 1960</i> that I last saw the deceased alive on <i>May 24th 1960</i> , and that death occurred at <i>2:00 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>C. F. Maloney, M.D.</i>		ADDRESS (Street, city or town, state) <i>57 Winters Lane</i>	
PHYSICIAN'S NAME (Type) <i>C. F. Maloney, M.D.</i>		DATE SIGNED <i>May 24-60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>B</i>		22b. DATE THEREOF <i>5-28-60</i>	22c. NAME OF CEMETERY OR CEMINATORY <i>Westview Mem. Gardens</i>
22d. LOCATION (City, town, or county) <i>Baltimore Co.</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Johnson</i>		24a. REC'D BY REGISTRAR <i>May 31 '60</i>	24b. REGISTRAR'S SIGNATURE <i>John M. Johnson</i>
ADDRESS <i>1011-13 N. Arlington Ave</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05515

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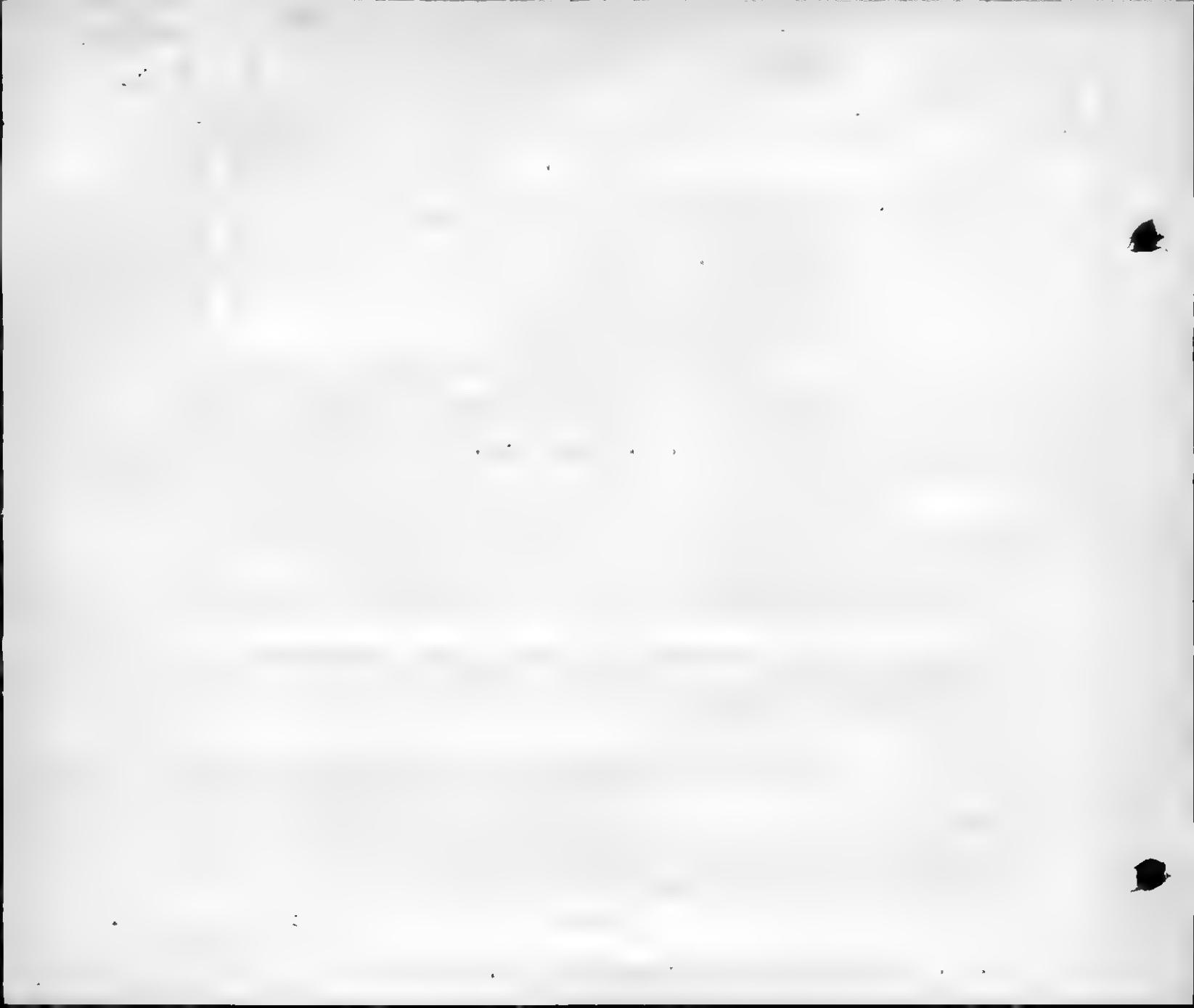
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		b. COUNTY Baltimore	
c. LENGTH OF STAY IN 1b 16, Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dogwood Road		d. STREET ADDRESS Dogwood Road	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles W. Ritter	First	Middle	Last
4. DATE OF DEATH May 13, 1960	Month	Day	Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/25/1871
9. AGE (In years on birthday) 89	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
13. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Daniels Mills	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas H Ritter	14. MOTHER'S MAIDEN NAME Racheal Grimes		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 218.09.5776A	17. INFORMANT Mrs. Truman Ritter	Address Dogwood Road
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH 10 min			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first (b) Generalized Arteriosclerosis (c) Hypertension - Early Stage Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3 - 1960 to 5 - 13, 1960 that I last saw the deceased alive on 5 - 13, 1960 , and that death occurred at 8 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thos H Ritter	ADDRESS (Street, city or town, state) 4509 Liberty Way DATE SIGNED 10/10/60		
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/16/60	22c. NAME OF CEMETERY OR CREMATORIAL Lorraine	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. T. Stansbury	ADDRESS 6411 Windsor Mill Rd.	24a. REC'D BY REGISTRAR DATE MAY 16 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Head

TO HOST
may be
in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5547

CERTIFICATE OF DEATH

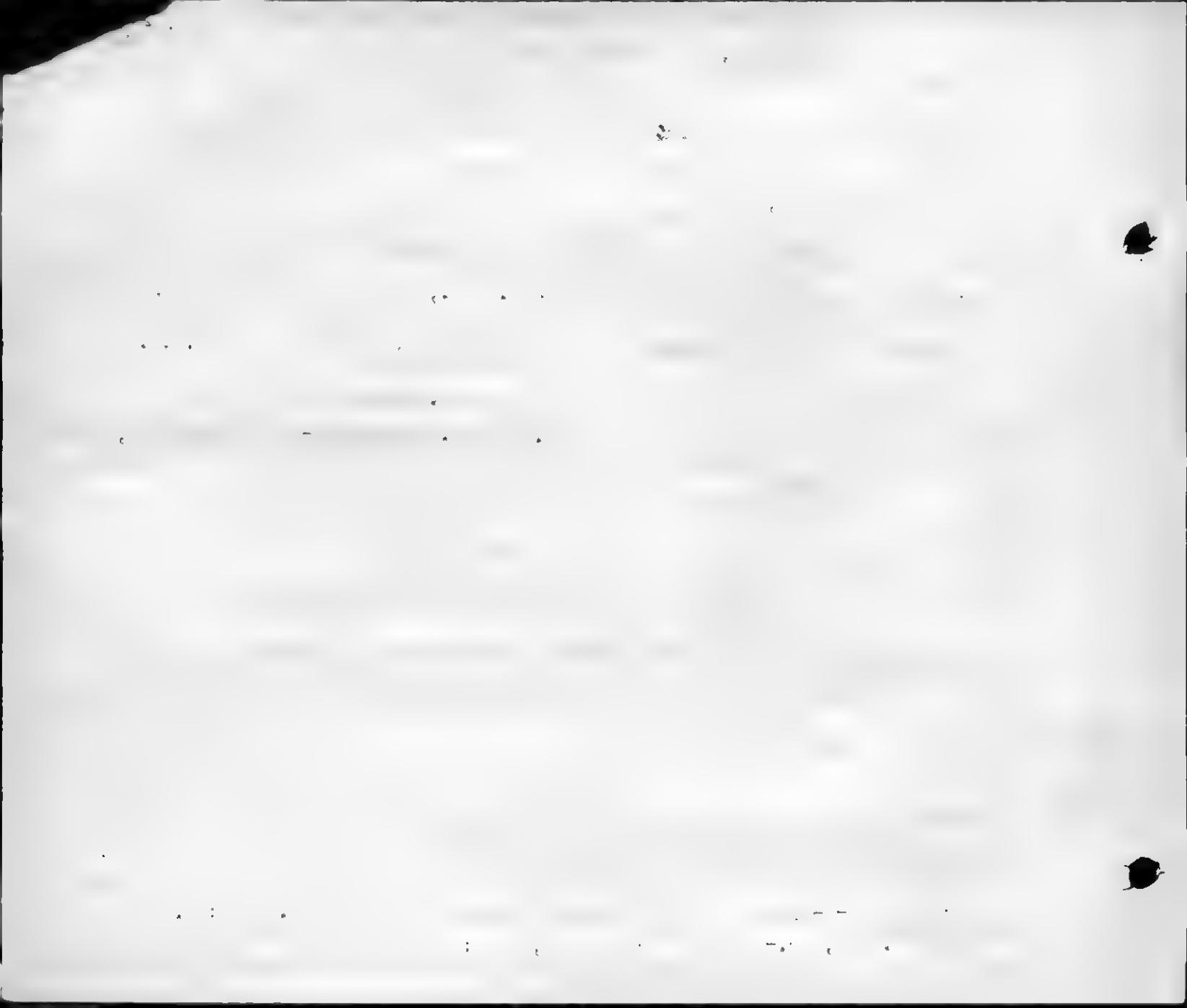
05516

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 53		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 21 Hilltop Road, Towson		d. STREET ADDRESS 21 Hilltop Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Anna	Middle Estelle	Last Rosenberger	4. DATE OF DEATH Jan. 17th., 1960	Month May	Day 4	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 17th., 1886		9. AGE (in years last birthday) 74 yrs.	10. IF UNDER 1 YEAR 3 Months	11. IF UNDER 24 HRS. 14 Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Lyell				14. MOTHER'S MAIDEN NAME Anna S. Matteer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. John H. Rosenberger-21 Hilltop Road, Towson		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion INTERVAL BETWEEN DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Hypertensive Arteriosclerotic DUE TO (c) CardioRenal Vascular Disease ONSET AND DEATH Sudden PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Belair	(County) Baltimore	(State) Md.	
21. I certify that I attended the deceased from Towson , 19 48 to May 4, 1960 that I last saw the deceased alive on April 4, 1960 and that death occurred at 4:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Charles F. O'Donnell, M.D. 7501 York Rd. Towson, Md. DATE SIGNED 5/4/60							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-7-1960	22c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cemetery	22d. LOCATION (City, town, or county) Belair Rd., Baltimore, Md.	(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE George J. Ruth, Inc.-1735 Harford Avenue, Belto:				24a. REC'D BY REGISTRAR DATE MAY 9 '60	24b. REGISTRAR'S SIGNATURE Charles S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5548

CERTIFICATE OF DEATH

65517

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Colgate</i>		c. LENGTH OF STAY IN lb <i>40 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Colgate</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Colgate (24)</i>	
3. NAME OF DECEASED (Type or print) <i>CATHERINE</i>		First <i>C</i>	Middle <i>A</i>
4. DATE OF DEATH <i>MAY 24 1960</i>		Last <i>Rosewag</i>	Month Day Year
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Jan 16 1888</i>		9. AGE (In years (last birthday) <i>72 yrs</i>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ind.</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>August Schmidt</i>	
14. MOTHER'S MAIDEN NAME <i>Kress Dorothea</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <i>None</i>	
16. SOCIAL SECURITY NO <i>Amelia Hermann - Same</i>		17. INFORMANT <i>Amelia Hermann - Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Hypertension</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Chronic</i>			
DUE TO <i>Chronic</i>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i>at work</i>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>5/10/60</i> to <i>5/24/60</i> that (I) (we) last saw the deceased alive on <i>5/10/60</i> and that death occurred at <i>4:30 P.M.</i> from the causes and on the date stated above.		22b. DATE SIGNED <i>5/25/60</i>	
22a. SIGNATURE <i>J. S. Connelly</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>J. S. Connelly</i>		22d. ADDRESS <i>116 E. 38th St. Baltimore 37</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial May 27-1960</i>		23b. DATE THEREOF <i>May 27-1960</i>	
23c. NAME OF CEMETERY OR CREMATORIUM <i>Oak Lawn Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Connelly - Easy Md.</i>		25a. REC'D. BY REGISTRAR DATE <i>May 27 60</i>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Curious G. Thomas</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

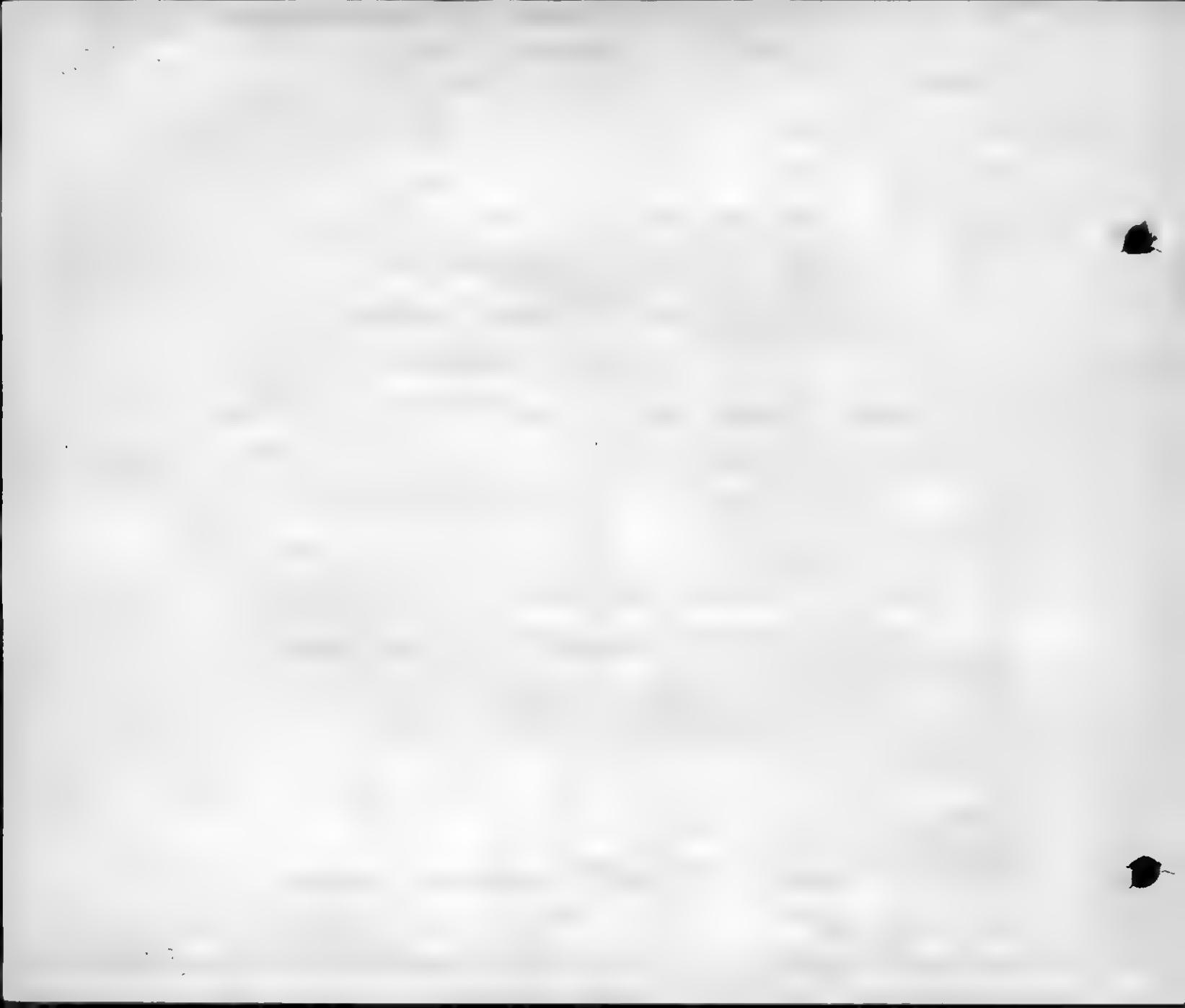
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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balt.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. COUNTY <i>Balt.</i>		c. LENGTH OF STAY IN 1b <i>42 yrs.</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>325 N. Marilyn Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Stefan</i>		First	Middle				
4. DATE OF DEATH <i>5 24 1960</i>		Month	Day Year				
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-21-1884</i>				
9. AGE (In years last birthday) <i>75 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>				
13. FATHER'S NAME <i>John Rothermel</i>	14. MOTHER'S MAIDEN NAME <i>Unknown</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bricklayer</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	11. BIRTHPLACE (State or foreign country) <i>Austria</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>212-07-7991</i>	17. INFORMANT <i>Mrs. Jeannette Rothermel</i>	Address <i>325 N. Marilyn Ave.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		COPROXANTINE arteriosclerotic Cardio Vascular disease			INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>arteriosclerotic Cardio</i>							
(c) DUE TO <i>Vascular disease</i>					2 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Prostate Hypertrophy with retention</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18. <i>White at work</i>					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Baltimore</i>	(County) <i>Md.</i>	(State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>Jan 1, 1960</i> to <i>May 24, 1960</i> that I last saw the deceased alive on <i>May 24, 1960</i> and that death occurred at <i>7:30 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>MBaumgadner M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Bury</i>		22b. DATE THEREOF <i>5-28-60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Parkwood</i>	22d. LOCATION (City, town, or county) <i>Baltimore</i>	(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jasabn J. Wong</i>		ADDRESS <i>7401 Belair Rd.</i>	24a. REC'D BY REGISTRAR DATE <i>MAY 26 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Charles E. Tracy</i>			



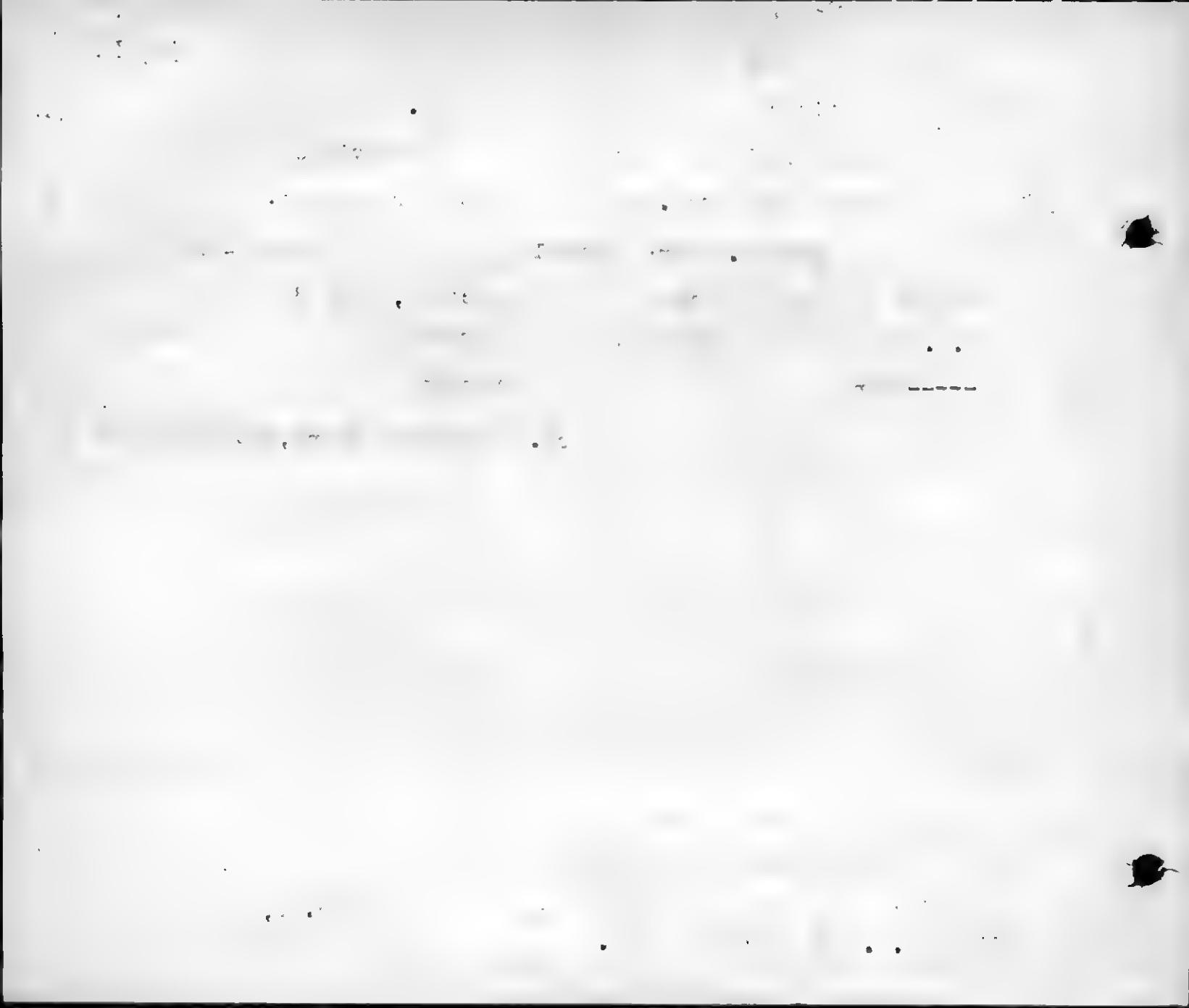
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5550

CERTIFICATE OF DEATH

05519

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Catonsville	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Conv. Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mary M. (Lena) Ruehl	Middle	Last
4. DATE OF DEATH	Month May	Year 22/60	Day
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1875
9. AGE (In years to birthday) 85	10. USUAL OCCUPATION (Give kind of work done during 10b. KIND OF BUSINESS OR INDUSTRY of working life, even if retired) H.W.	11. BIRTHPLACE (State or foreign country) Germany	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Neun	14. MOTHER'S MAIDEN NAME Unknown	Address Catonsville Mrs. Wilhelmina Noone, 412 Overbrook Rd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO	17. INFORMANT
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 442X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) DUE TO CIRCULATORY-RESPIRATORY DISEASE CIRCULATORY COLLAPSE			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/1 to 5/22/1960 , that (I) (we) last saw the deceased alive on 5/22/1960 , and that death occurred at 522 M, from the causes and on the date stated above.		22d. DATE SIGNED 5/22/60	
22e. SIGNATURE John H. Ruehl		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22f. PHYSICIAN'S NAME (Type) John H. Ruehl		22g. ADDRESS 5500 Edmondson Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 25/60	23c. NAME OF CEMETERY OR CREMATORIAL London Park	23d. LOCATION (City, town, or county) Baltimore, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Witke F.D. 4101 Edmondson Ave.		ADDRESS Witke F.D. 4101 Edmondson Ave.	25a. REC'D BY REGISTRAR DATE MAY 26 '60
			25b. REGISTRAR'S SIGNATURE Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

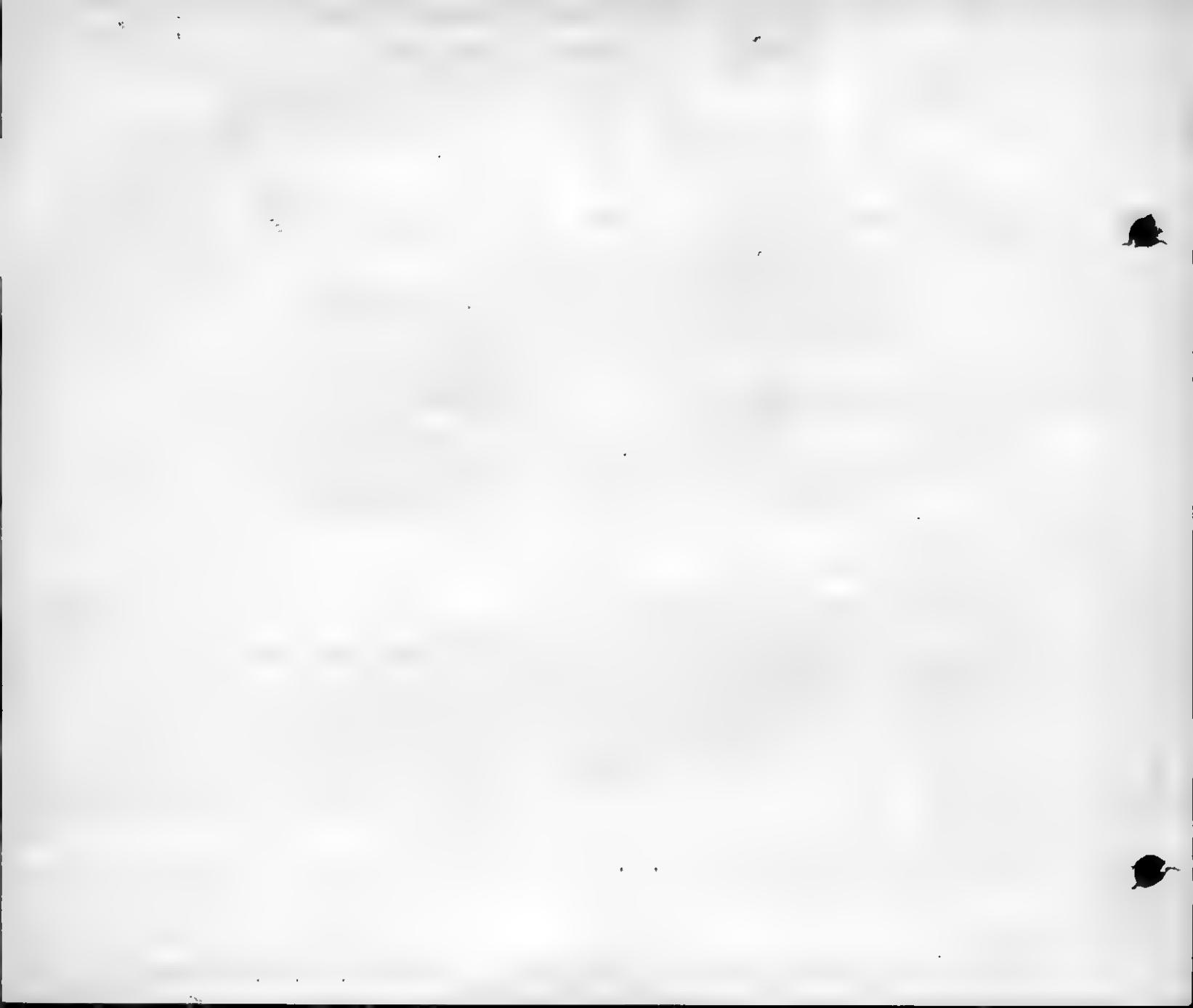
5551

CERTIFICATE OF DEATH

05520

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 26 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3114		d. STREET ADDRESS 511 Linden Heights Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Lena	Middle	Last Sacks	4. DATE OF DEATH Sept. 14, 1879	Month May	Day 31	Year 19 60
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14, 1879	9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Russia ✓	
13. FATHER'S NAME Unknown Samuel Lipsitz		14. MOTHER'S MAIDEN NAME Unknown Sarah ?					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i>						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>15221</i>		DUE TO					
		(b) <i>Generalized arteriosclerosis</i>					
		DUE TO					
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)
						(State)	
21. I certify that I attended the deceased from <u>May 5, 1960</u> to <u>May 31, 1960</u> that I last saw the deceased alive on <u>May 31, 1960</u> , and that death occurred at <u>2:30 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE	<i>Stella Wachsler</i>		M.D.	SPRING GROVE STATE HOSPITAL 5-31-60			
PHYSICIAN'S NAME (Type)	Stella Wachsler, M. D.		Catonsville 28, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 3, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Kovna Cong		22d. LOCATION (City, town, or county) Rosedale, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Sol. Levinson & Bros. Inc. 6010 Reist Rd.	ADDRESS			24a. REC'D BY REGISTRAR DATE JUN 6 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur J. Hanna</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5552

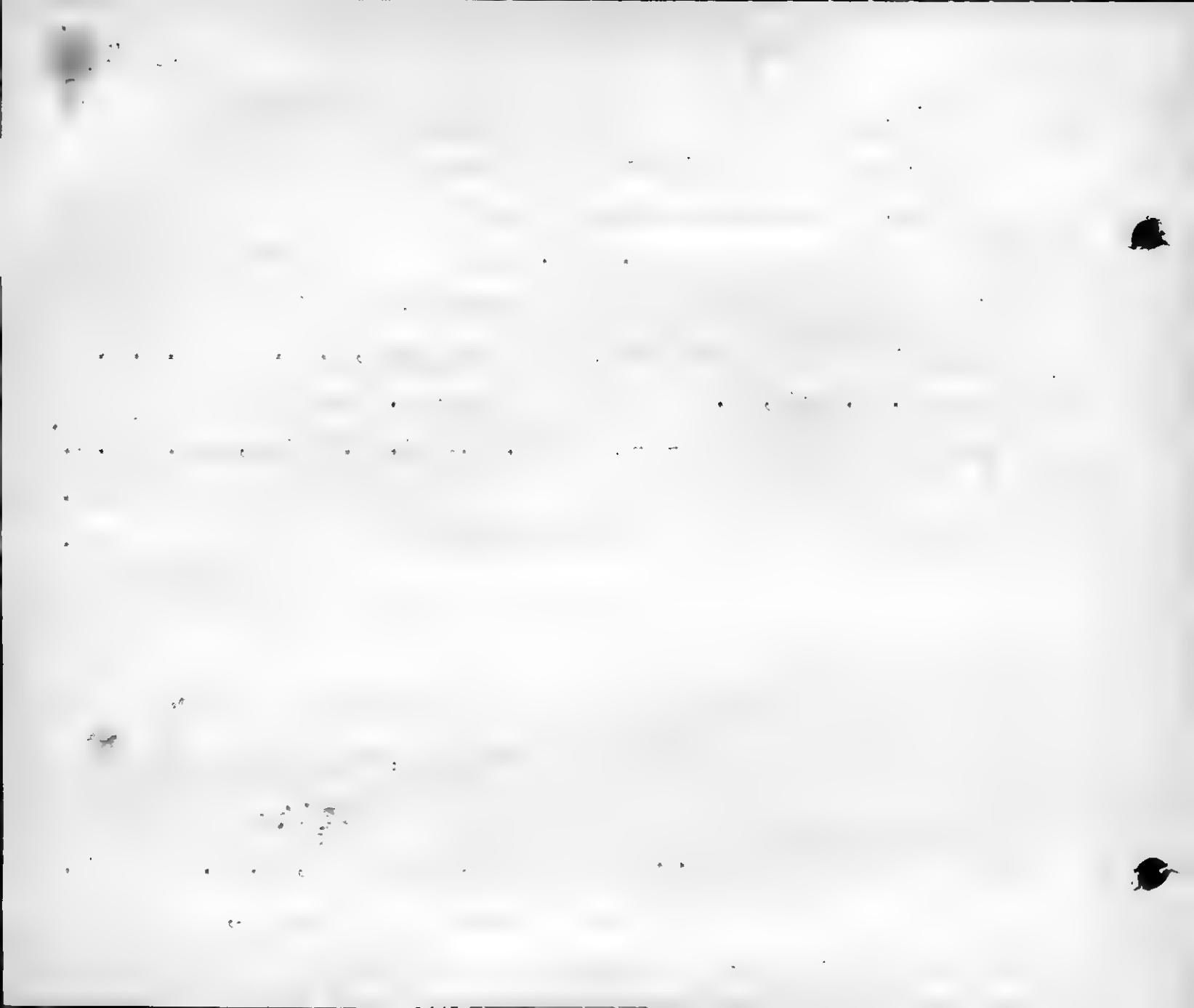
CERTIFICATE OF DEATH

05521

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 18 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 3836 Bon View Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ARTHUR	Middle R. ST. CLAIR	4. DATE OF DEATH May 29 1960	Month	Day	Year	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH December 25, 1923	9. AGE (In years last birthday) 36 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dye Maker		10b. KIND OF BUSINESS OR INDUSTRY Dye Company		11. BIRTHPLACE (State or foreign country) Morgantown, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Arthur R. St. Clair, Sr.		14. MOTHER'S MAIDEN NAME Sarah E. Bowman		Address Howard Div.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 218-14-7506		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Balto. 18, Md. Ft.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA		DUE TO CHRONIC GLOMERULONEPHRITIS		INTERVAL BETWEEN ONSET AND DEATH 2 mos.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO		6 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May 11 1960 to May 29 1960 that (X) (we) last saw the deceased alive on May 29 1960 and that death occurred at 12 M. from the causes and on the date stated above							
22a. SIGNATURE <i>Moses Lichtig</i>		M. D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/30/60			
22c. PHYSICIAN'S NAME (Type) MOSES LICHTIG, M.D.		22d. ADDRESS VAH, Baltimore 18, Md. Ft. Howard Div.					
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF 5-29-60		23c. NAME OF CEMETERY OR CREMATORIAL Lawn Wood Cemetery		23d. LOCATION (City, town, or county) Morgantown, West Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home, Baltimore, Maryland		ADDRESS		25a. REC'D BY REGISTRAR Arthur S. House		25b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be examined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5553

CERTIFICATE OF DEATH

05522

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <i>Rosemont</i>		b. COUNTY <i>Baltimore</i>	
c. LENGTH OF STAY IN 1b <i>35 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rosemont</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2819 Pennsylvania Ave</i>		d. STREET ADDRESS <i>2819 Pennsylvania Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Katherine</i>		4. DATE OF DEATH <i>5/24/1960</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
S. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/12/1886</i>
9. AGE (In years last birthday) <i>73 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	13. FATHER'S NAME <i>Frank Guntermann</i>		
14. MOTHER'S MAIDEN NAME <i>Mary Mueller</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) <i>✓</i>		
16. SOCIAL SECURITY NO. <i>✓</i>	17. INFORMANT <i>Mrs. Theresa C. Thompson</i>	Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 60 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Cerebral Thrombosis, left (c) DUE TO Diabetes Mellitus			
INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <i>5A</i>		(County) <i>Frederick</i>	
(State) <i>Md</i>			
21. I certify that I attended the deceased from <i>5/23</i> , 19 <i>53</i> , to <i>5/24</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>5/23</i> , 19 <i>60</i> , and that death occurred at <i>5A</i> M., from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <i>1227 Wards Blvd, Baltimore 30415, Md</i>			
DATE SIGNED <i>John P. Urlock Jr.</i>			
ACTUAL SIGNATURE <i>John P. Urlock Jr.</i>		PHYSICIAN'S NAME (Type) <i>John P. Urlock Jr.</i>	
22a. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/27/60</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>London Park Cemetery</i>		22d. LOCATION (City, town, or county) <i>Frederick, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Cowan & Son</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 25 '60</i>	
ADDRESS <i>Collins St.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



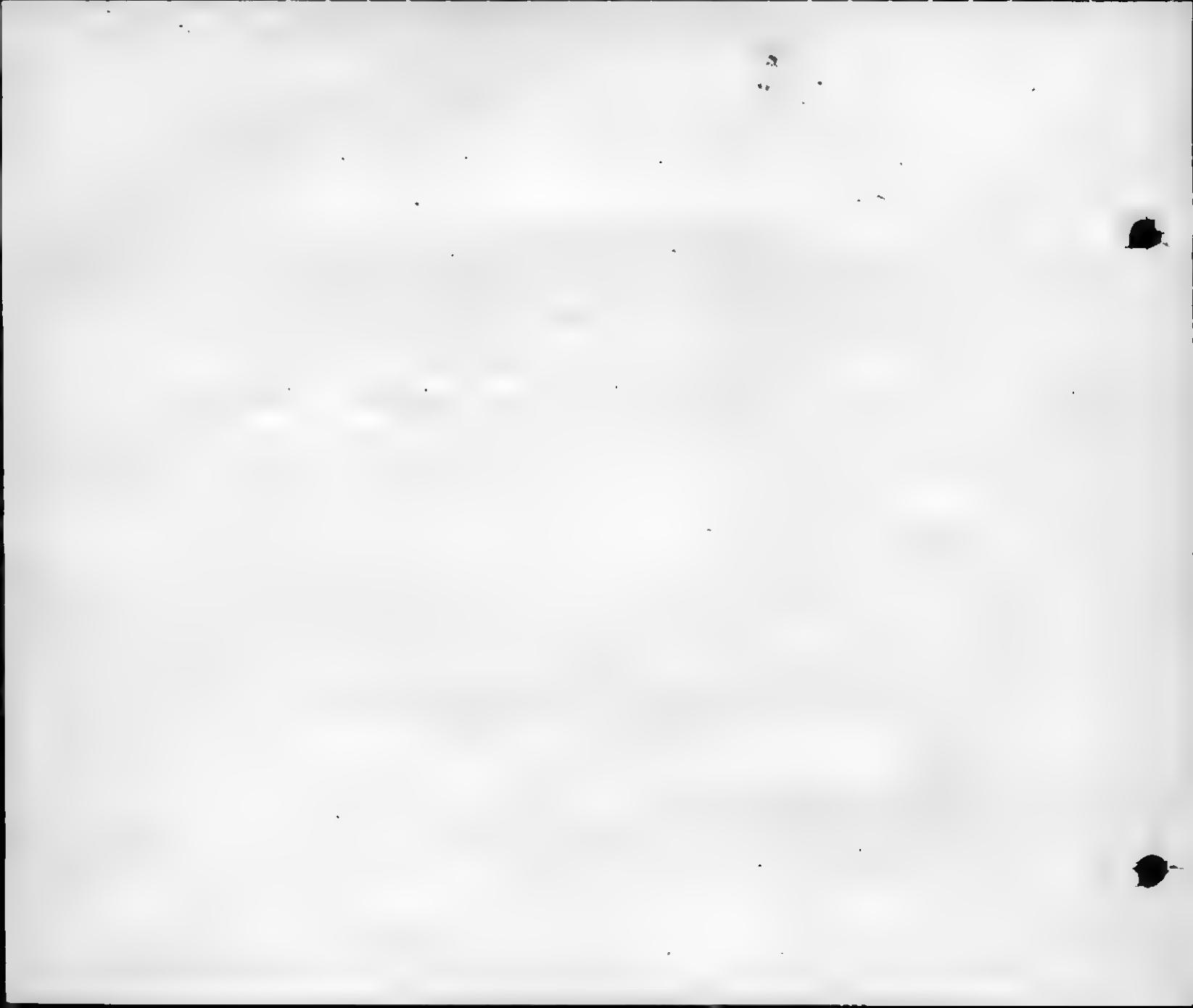
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5554 05523

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE CALIFORNIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 7 yrs - 5 mo	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HOLLYWOOD	
3. NAME OF DECEASED (Type or print) ELIZABETH SCHNEIDER		4. DATE OF DEATH Month MAY Day 19 Year 1860	
5. SEX F		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 10, 1870	
9. AGE (in years last birthday) 90 yrs		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME EDWARD KELLER		14. MOTHER'S MAIDEN NAME Elizabeth (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Frank L. Smith Jr. - Cockeysville Md		18. ADDRESS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO 422 Due to (b) (c)		Cerebral Vascular Accident Active - Atherosclerotic Cardiovascular Disease	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-12 , 19 53 , to 5-18 , 19 60 , that (I) (we) last saw the deceased alive on 5-18 , 19 60 , and that death occurred at 1150 , from the causes and on the date stated above			
22a. SIGNATURE Walter T. Kees		22b. DATE SIGNED 5/19/60	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEE		22d. ADDRESS COCKEYSVILLE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-21-60	
23c. NAME OF CEMETERY OR CREMATORIAL Green Mount Cemetery		23d. LOCATION (City, town, or county) Baltimore (State)	
24. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR DATE May 24 '60	
		25b. REGISTRAR'S SIGNATURE Walter S. Thomas	

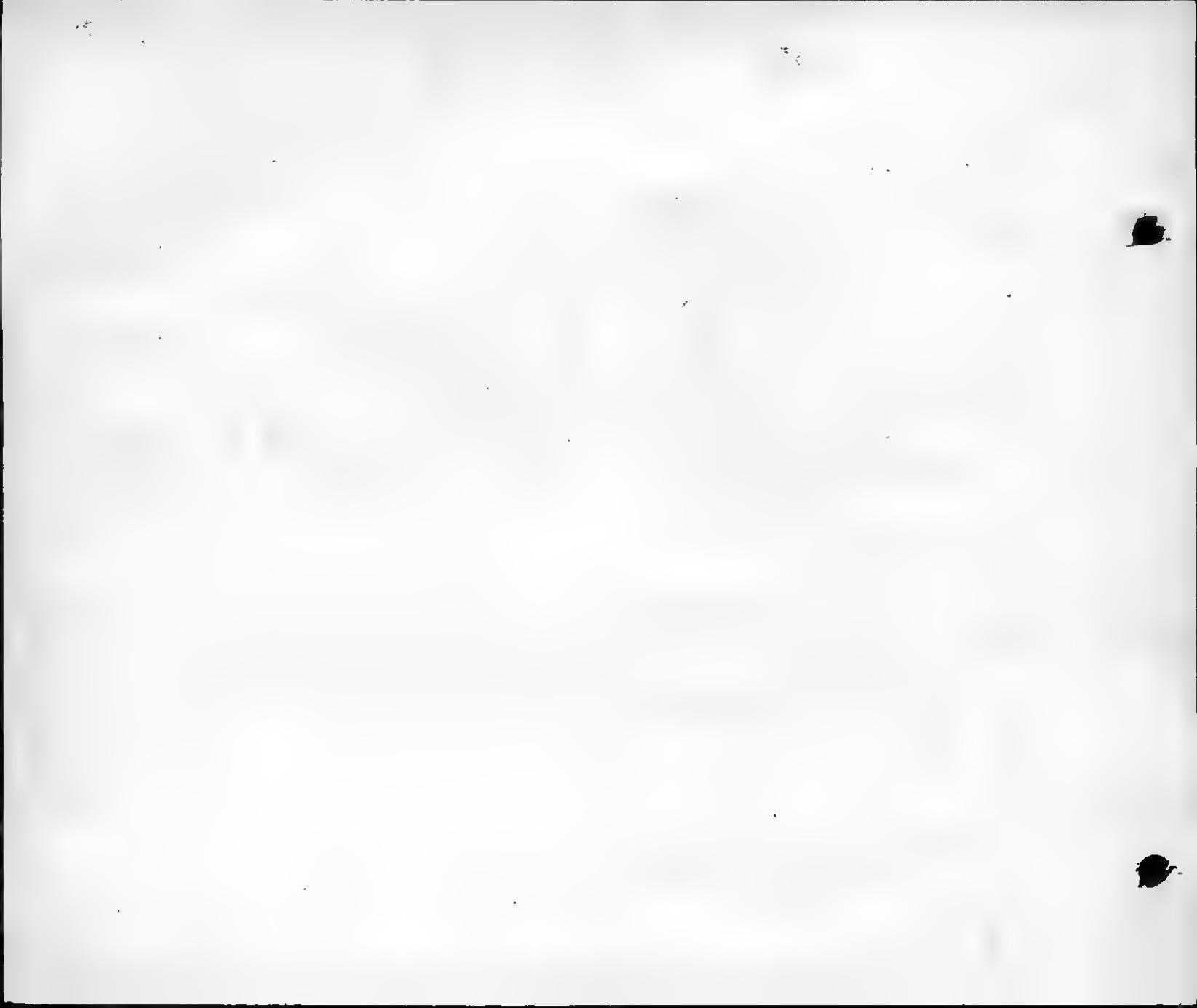


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician, and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5555 CERTIFICATE OF DEATH

05524
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House in lines</i>		d. STREET ADDRESS <i>4314 Leestertown Rd</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Morris Leiden</i>		First <i>Morris</i>	Middle <i>Leiden</i>
4. DATE OF DEATH <i>5 - 19 - 1960</i>		Month <i>5</i>	Day <i>19</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>78 yrs.</i>		9. AGE (In years last birthday) yrs. <i>78</i>	10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Taylor</i>	10c. BIRTHPLACE (State or foreign country) <i>Poland</i>
11. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
12. FATHER'S NAME <i>Harry</i>		13. MOTHER'S MAIDEN NAME <i>Mollie</i>	
14. INFORMANT <i>Harry Leiden - 3907 Grantham Ave</i>		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>422-1</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterosclerosis C. V. Disease</i>		18. INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>422-1</i>			
DUE TO <i>Arterosclerosis C. V. Disease</i>			
DUE TO <i>422-1</i>			
DUE TO <i>Arterosclerosis C. V. Disease</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>case 2C</i> , 19 <i>60</i> , to <i>May 18</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>May 18</i> , 19 <i>60</i> , and that death occurred at <i>4 P.M.</i> from the causes and on the date stated above.		22. ADDRESS (Street, City or town, state) <i>8818 Restoration Rd</i>	
ACTUAL SIGNATURE <i>Manuel Levin</i>		DATE SIGNED <i>19/60</i>	
PHYSICIAN'S NAME (Type) <i>MANUEL LEVIN, MD</i>		23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
22b. DATE THEREOF <i>5-20-60</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Rosedale</i>	
22d. LOCATION (City, town, or county) <i>Baltimore Md</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 20 '60</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	
ADDRESS <i>2100 Eutaw Pl</i>			



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5550 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

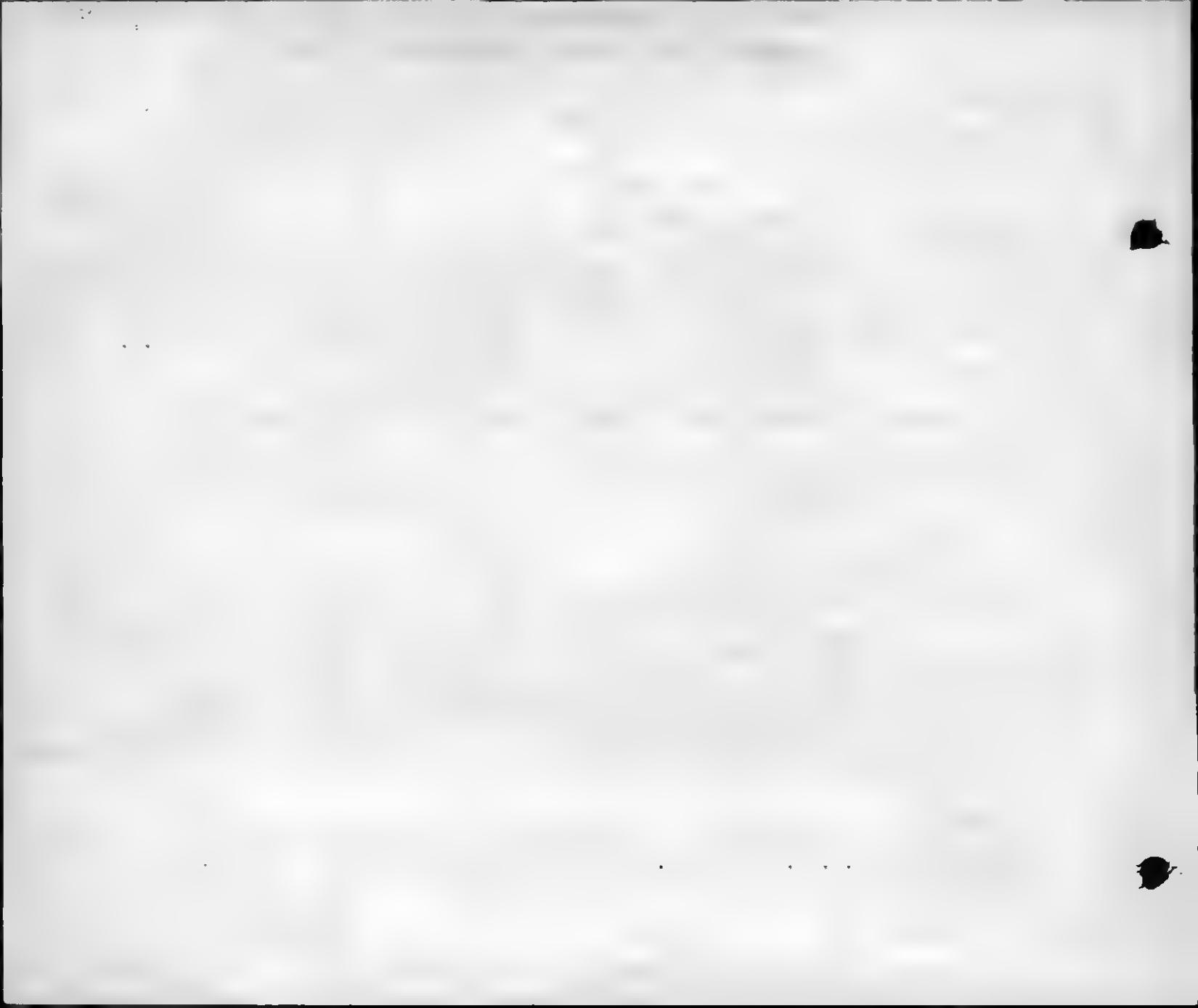
05525

Reg. Dist. No.

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only "Pending" is necessary, please execute certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial-cremation, or removal.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD b. COUNTY Balt. MD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		d. STREET ADDRESS 1506 Cecil Ave	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2100 Cecil Ave				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Popele		Middle Alice		4. DATE OF DEATH Month May Day 13 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1913	9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leil M. Collins				14. MOTHER'S MAIDEN NAME Leil M. Collins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Hilton Church 5906 Cecil Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420 of Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO [b] Ca. No vaccine in circulation DUE TO [c]							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) J. S. H. Kinsler M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED May 31, 1960		
22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/3/60	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS CEDAR HILL	22d. LOCATION (City, town, or county) (State) BALTO. MD.				
23. FUNERAL DIRECTOR'S SIGNATURE J. T. STANSBURY BALTO. MD.	24a. REC'D BY REGISTRAR DATE JUN 3 '60	24b. REGISTRAR'S SIGNATURE Charles S. Kinsler					



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05526

FOR STATE
HEALTH-DEPT.

TO DEPARTMENT: This certificate should be executed within 24 hours of the death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours of death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i>		Reg. Dist. No. <i>5405</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reisterstown</i>		c. LENGTH OF STAY IN 1b <i>3 yrs.</i>		b. COUNTY <i>Baltimore</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reisterstown, Md.</i>		d. STREET ADDRESS <i>7103 Mex 71, Glen Falls Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>Benjamin D. Sharkey</i>		First	Middle	Last	4. DATE OF DEATH <i>May 20, 1960</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 12, 1894</i>	9. AGE (in years last birthday) <i>66 yrs</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ht. Saint Agnes</i>		11. BIRTHPLACE (State or foreign country) <i>Frederick, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Benjamin F. Sharkey</i>		14. MOTHER'S MAIDEN NAME <i>Levina L. [illegible]</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>612-11-1068</i>		17. INFORMANT <i>Mr. C. J. [illegible], [illegible]</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH <i>15 min.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)		Coronary artery disease		2 yrs	
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>None</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>None</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	
20f. (City or town) <i>None</i>				(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>D. D. Caples</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>5-20-60</i>	
EXAMINER'S NAME (Type) <i>D. D. Caples</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>1. b. y 23, 1960</i>		22b. DATE THEREOF <i>May 23, 1960</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Administrator Cemetery, Inc., West Baltimore, Md.</i>	
22d. LOCATION (City, town, or county) <i>Pikesville</i>				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. H. Newell, 1100 Reisterstown Rd.</i>		ADDRESS <i>Pikesville 8</i>		24a. REC'D BY REGISTRAR DATE <i>May 26 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Charles S. Knobell</i>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3 & 13 Phone 6-77 from Funeral Director 5/11/60 jml

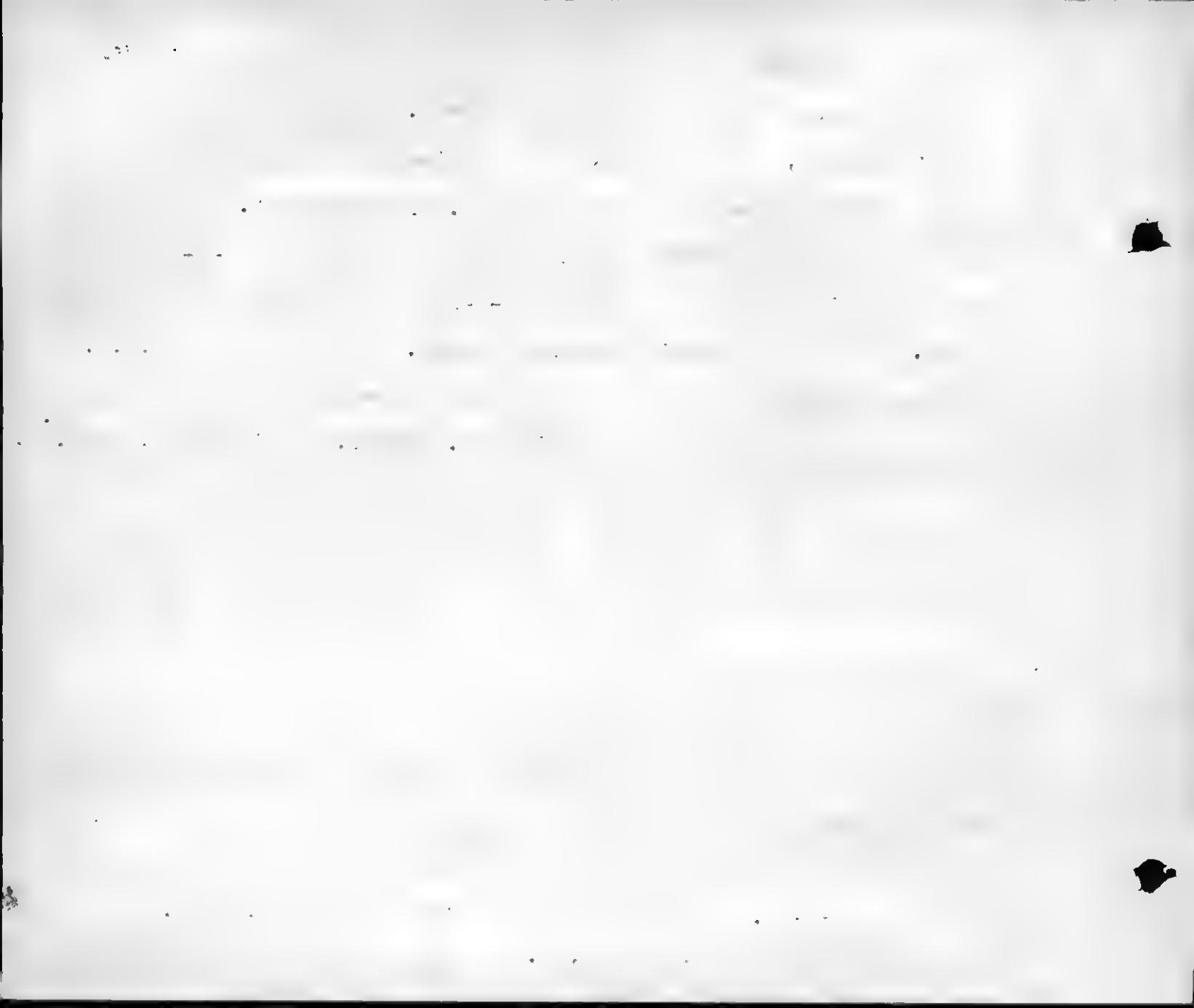
05527

5395

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived—If institution, Residence before admission) a. STATE Penn.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12,		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 343 Old Trail		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmont	
3. NAME OF DECEASED (Type or print) Robert Jackson Shields		d. STREET ADDRESS 29 E. Pittsburgh St.	
4. DATE OF DEATH 5-5-60		Month May	Day Year 19
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-9-1870
9. AGE (In years last birthday) 90 yrs		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt.		10b. KIND OF BUSINESS OR INDUSTRY public schools	
10c. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Shields		14. MOTHER'S MAIDEN NAME Mary Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. INFORMANT Hubert I. Snyder, 343 Old Trail, Balto. 12,	
17. ADDRESS Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 420-1 Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) Coronary Occlusion (c) Coronary Heart Disease	
		INTERVAL BETWEEN ONSET AND DEATH 25 MINUTES	
		DUE TO (b) Coronary Occlusion (c) Coronary Heart Disease	
		INTERVAL BETWEEN ONSET AND DEATH 30 MINUTES	
		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 5 , 1960, to May 5 , 1960, that I last saw the deceased alive on May 5 , 1960, and that death occurred at 5:40 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Towson, Md.	
ACTUAL SIGNATURE Donald L. Somerville		DATE SIGNED 5/6/60	
PHYSICIAN'S NAME (Type) DONALD L. SOMERVILLE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-8-60.	
22c. NAME OF CEMETERY OR CREMATORY Delmont Presbyterian		22d. LOCATION (City, town, or county) Delmont, Penn.	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.		24a. REC'D BY REGISTRAR MAY 9 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5557

CERTIFICATE OF DEATH

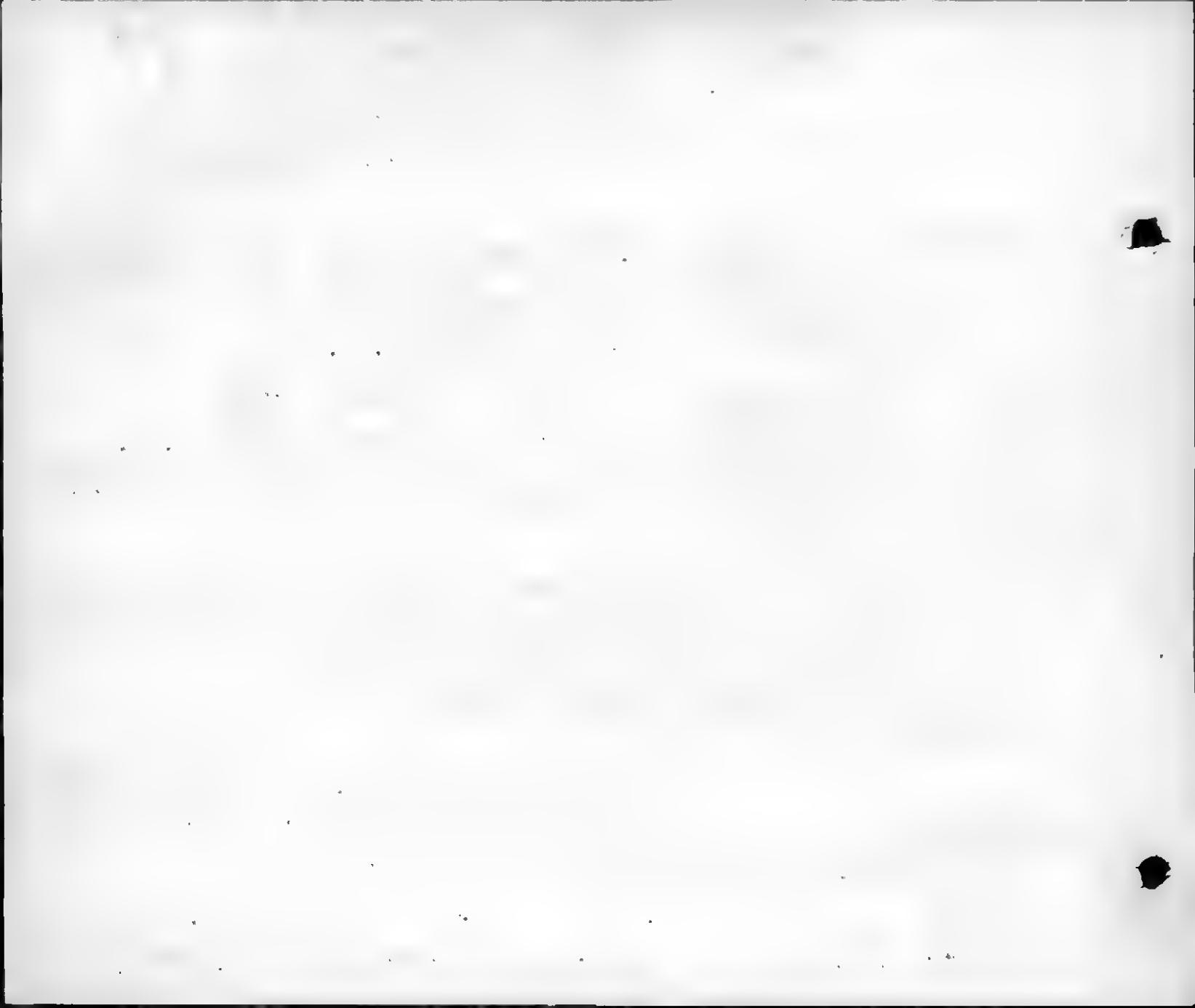
05528

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Kingsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 185		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mattie		First M.	Middle Shipley
4. DATE OF DEATH May 24, 1960	Month Day Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1874
9. AGE (In years from birthday) 86 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Howard Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown Tetlow		14. MOTHER'S MAIDEN NAME Unknown Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Earl Shipley Box 185 Kingsville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b). DUE TO (c) <u>Congestive heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Arteriosclerosis generalized</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 1, 1960</u> to <u>May 24, 1960</u> and that I last saw the deceased alive on <u>May 23, 1960</u> , and that death occurred at <u>8:20 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. <u>9660 Belair Road</u> DATE SIGNED <u>Theodore F. Evans</u> <u>May 25, 1960</u>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <u>Theodore F. Evans</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 27, 1960	
22c. NAME OF CEMETERY OR CREMATORIUM St. Michael's Lutheran		22d. LOCATION (City, town, or county) Perry Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lorraine Funeral Home</u>		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR DATE <u>MAY 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Julia S. Thrush</u>	

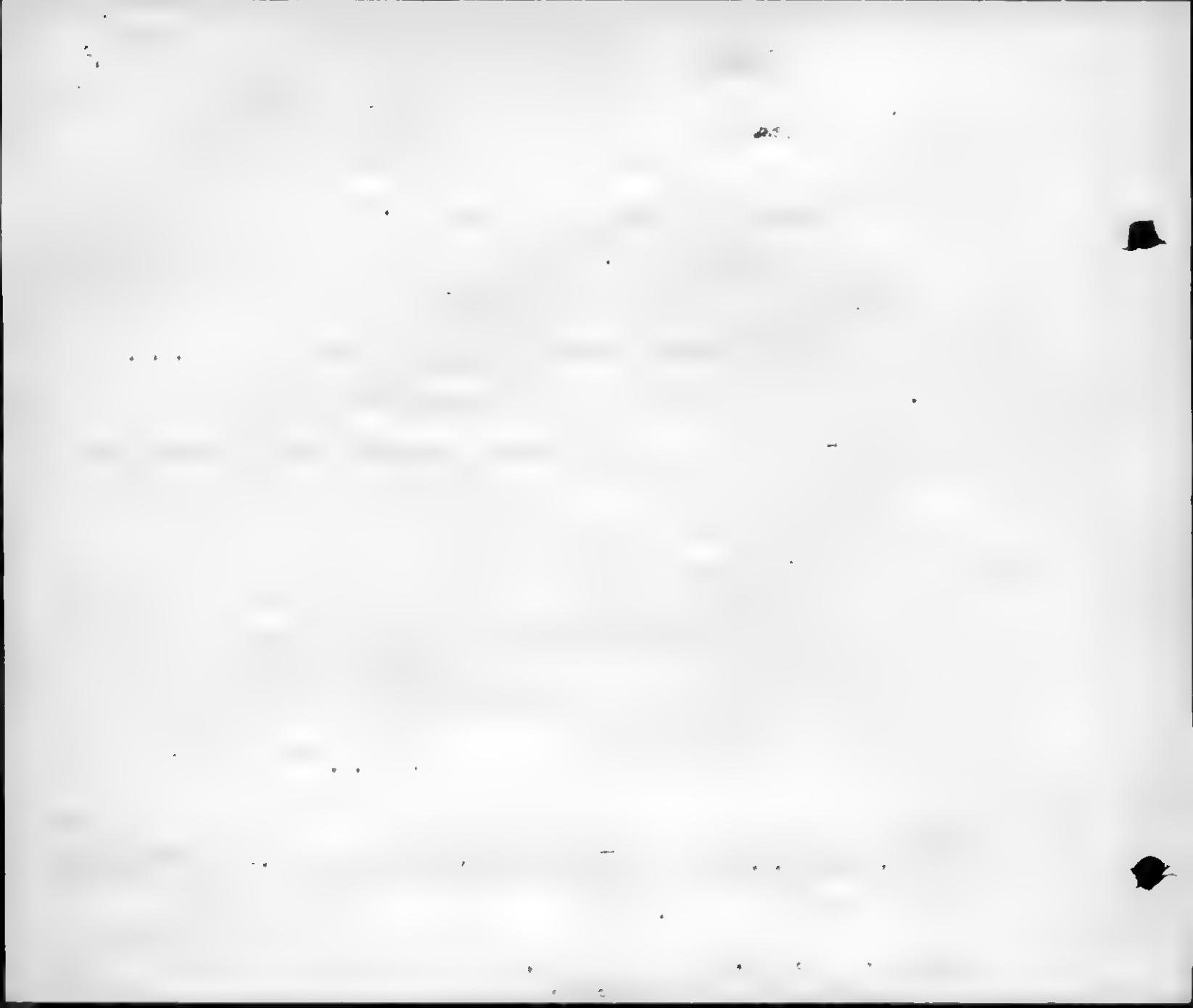


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5558 CERTIFICATE OF DEATH

05529

1. PLACE OF DEATH a. COUNTY BALTIMORE		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 5 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS 2219 E. NORTH AVENUE		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) THOMAS		First W. Middle SHIPLEY		4. DATE OF DEATH MAY 25		Month MAY		Day 25 Year 1960	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 4/16/91		9. AGE (In years last birthday) 69 yrs.	
				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
10a. USLAI OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY CAPPING & SEALING		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JAMES B. SHIPLEY		14. MOTHER'S MAIDEN NAME MARY COLE							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WH-1		17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 03X		UREMIA						INTERVAL BETWEEN ONSET AND DEATH 2 months	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 03X		DUE TO MULTIPLE MYELOMA						1 year	
		b. 03X		AMYLOIDOSIS				3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) PULMONARY EDEMA							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <input type="checkbox"/> p. m. <input checked="" type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) May 20 1960 to May 25 1960		(County) 2:15 A.M. (State) 18, MD.	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 20 1960 to May 25 1960 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 25 1960 , and that death occurred at 2:15 A.M. from the causes and on the date stated above.									
22a. SIGNATURE <i>Thomas R. Hood</i>		M D		ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 5/25/60	
22a. SIGNATURE <i>Thomas R. Hood</i>									
22d. ADDRESS VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-28-60		23c. NAME OF CEMETERY OR CREMATORIUM MT. OLIVET		23d. LOCATION (City, town, or county) BALTIMORE, MARYLAND		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, Inc., 5305 Harford Rd.		ADDRESS Baltimore, Md.		25a. REC'D BY REGISTRAR MAY 31 '60		25b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5559 CERTIFICATE OF DEATH

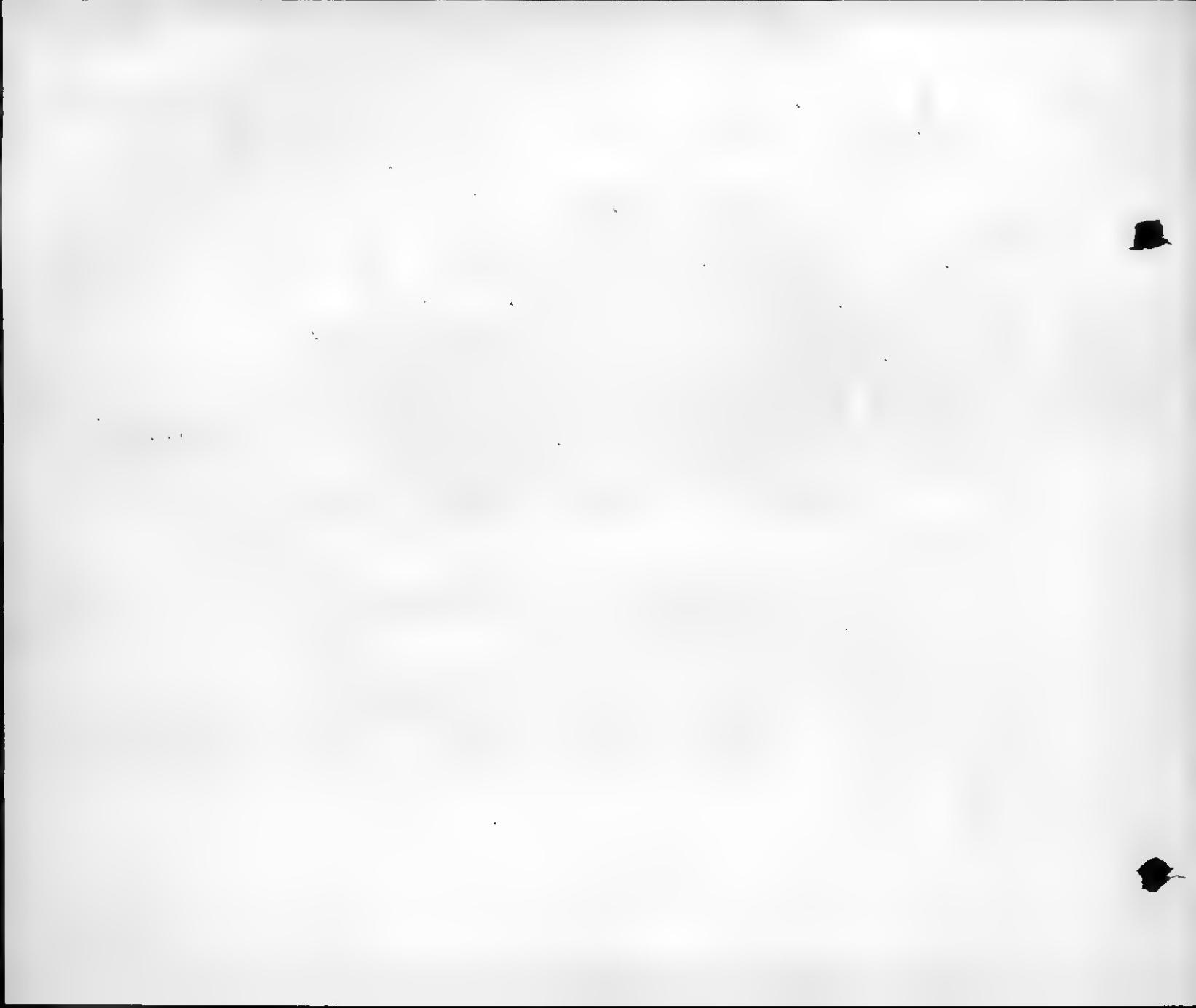
05530

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Willa Nova</i>		c. LENGTH OF STAY IN 1b <i>11 days</i>	
d. NAME OF HOSPITAL (If not an hospital, give street address) OR INSTITUTION <i>Nathaniel Port-Parson's Home</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <i>Pikesville Park Road</i>	
3. NAME OF DECEASED (Type or print) <i>Carrie Alice Smith</i>		First <i>C</i>	Middle <i>A</i>
4. DATE OF DEATH <i>May 1 1960</i>		Month <i>May</i>	Day <i>1</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Aug 3 1867</i>		9. AGE (In years, last birthday) <i>92 yrs</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <i>1</i> Days <i>0</i> Hours <i>0</i> Min. <i>12 CITIZEN OF WHAT COUNTRY?</i> <i>U.S.A.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>11. BIRTHPLACE (State or foreign country) Maryland</i>	
13. FATHER'S NAME <i>Joseph Bates</i>		14. MOTHER'S MAIDEN NAME <i>Margaret</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>2 Harold Smith 937 Mulford Park Road</i>	
17. INFORMANT <i>Paul H. Royse</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420-C</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b)</i> DUE TO <i>(c)</i>	
		INTERVAL BETWEEN ONSET AND DEATH <i>few years</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 19, 1958</i> to <i>1 may 1960</i> , that I last saw the deceased alive on <i>11 Apr 1960</i> , and that death occurred at <i>8:30 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>803 Reisterstown Rd, Pikesville, Md.</i>	
ACTUAL SIGNATURE <i>Paul H Royse</i>		DATE SIGNED <i>1 may 60</i>	
PHYSICIAN'S NAME (Type) <i>PAUL H Royse</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial May 4-1960</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Elmwood Bldg</i>	
22d. LOCATION (City, town, or county) <i>Pikesville Maryland</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Burke Funeral Home</i>		24a. REC'D BY REGISTRAR ADDRESS <i>3631 Falls Rd</i>	
		DATE MAY 4 '60	
		24b. REGISTRAR'S SIGNATURE <i>Albert S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

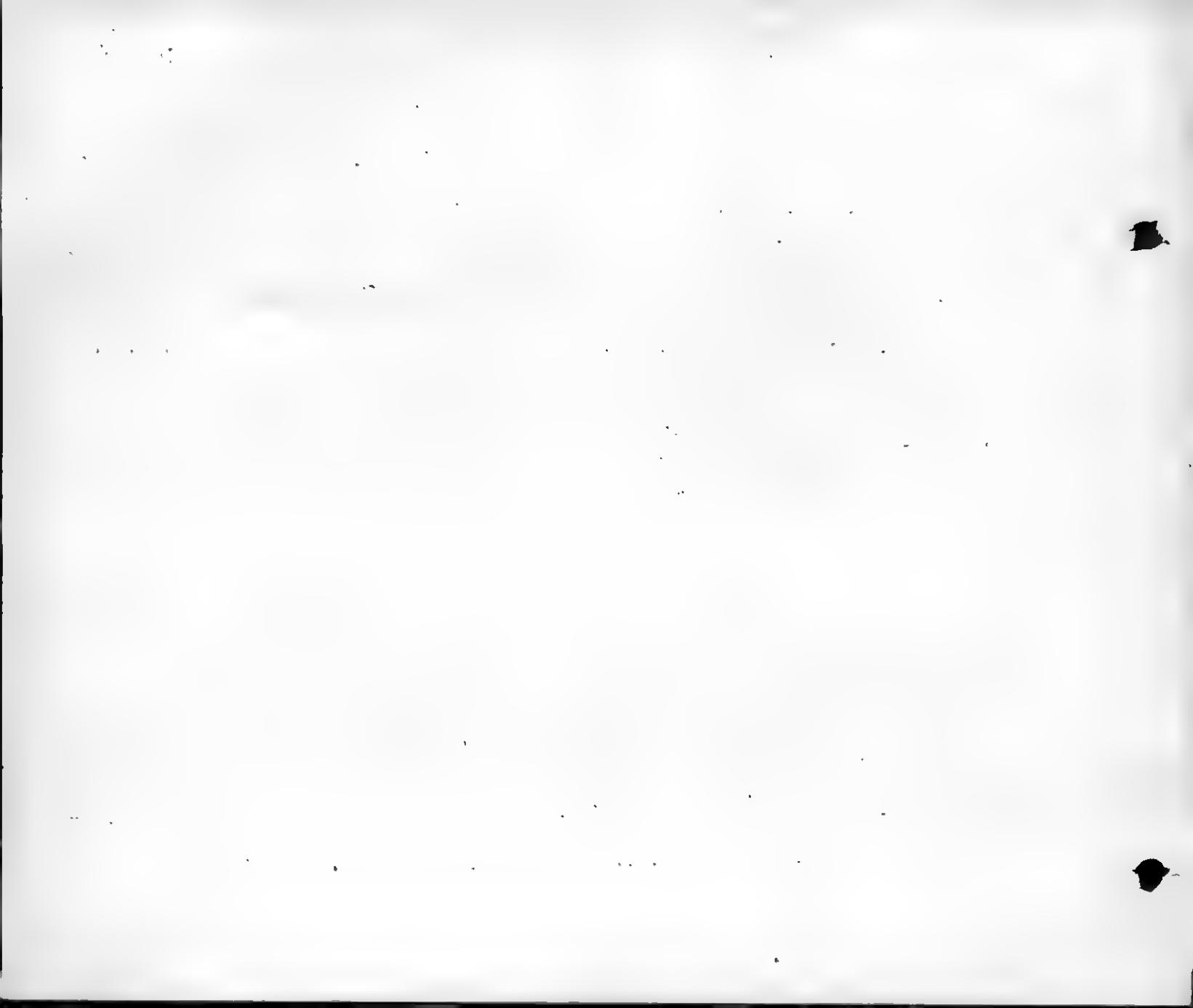
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5560

CERTIFICATE OF DEATH

05531

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) First Ida		4. DATE OF DEATH Last Spurrier	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 16, 1883	
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Schaefer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) Unknown		16. SOCIAL SECURITY NO. 210-09-49803	
17. INFORMANT Unknown		Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422-1 Terminal pneumonia			
DUE TO Conditions, if any which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic cardiovascular disease			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 20d. INJURY OCCURRED p. m. 19 While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 30, 1960, to May 5, 1960, that I last saw the deceased alive on May 5, 1960, and that death occurred at 3:30 P.M., from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Bruno Radauskas, M.D. SPRING GROVE STATE HOSPITAL 5-5-60			
DATE SIGNED			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type) Bruno Radauskas, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-9-60	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS WESTERN		22d. LOCATION (City, town, or county) BALTIMORE, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George L. Schwab Funeral Home Francis W. Miller 2101 Frederick Ave		24a. REC'D BY REGISTRAR DATE MAY 9 '60	
24b. REGISTRAR'S SIGNATURE Orinus S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05532

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
Baltimore		Catonsville				a. STATE Md		b. COUNTY Baltimore			
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
						52 Catonsville		210 March Ave			
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
William		J.		Arthur		Kaufman		May 29 1960		1960	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years at birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.	
Male		Negro		Widowed		April 8/1908		50			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		10c. BIRTHPLACE (State or foreign country)		11. CITIZEN OF WHAT COUNTRY?					
Laborer				Catonsville Md		USA					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address							
Arthur Stewart		Josephine Hook		210 March Ave							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH			
(Yes, no, or unknown)		210-05-4199		Mrs Margaret King		Cardiovascular Disease (thrombosis)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO		Cardiovascular Disease							
40											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)									
		DUE TO									
		(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE		Geo. S. M. Kieffer M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)										May 29, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)				(State)	
Burial		6-1-60		Western Star Cem		Catonsville				Md	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		578 W. Biddle St.		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Myra Tracey & J. Deemley						JUN 2 '60		Arthur S. Kline			

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any entry is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.



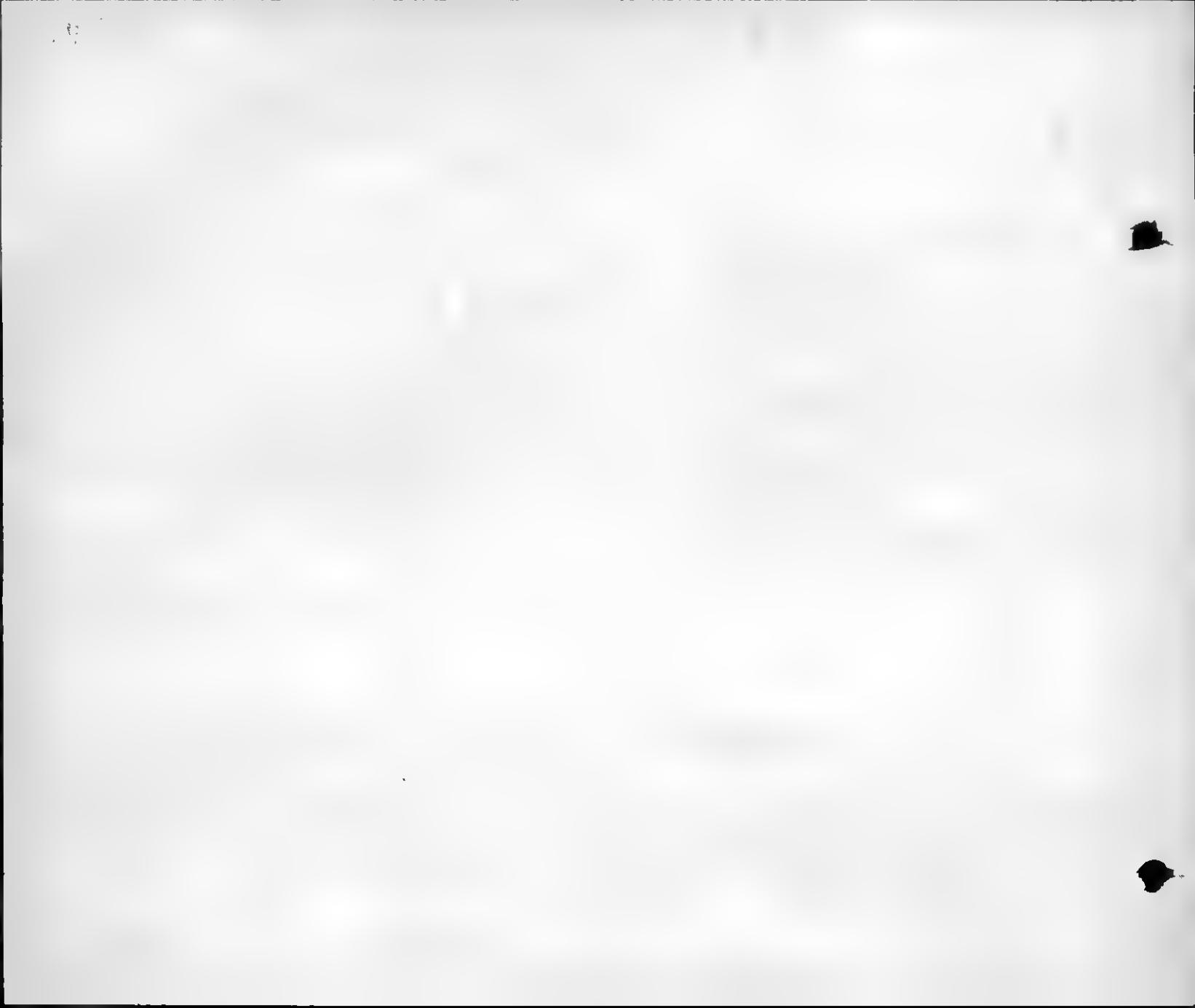
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5562 **CERTIFICATE OF DEATH** 05533

Reg. Dist. No. _____

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived—If institution: Residence before admission) a. STATE Maryland b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Daisy L Stuhr		d. STREET ADDRESS 7710 Philadelphia Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Daisy L	Middle Stuhr	Last May 3/60
4. DATE OF DEATH	Month May	Day 3	Year 1960
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11 1890
9. AGE (In years lost birthday) 69	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home	10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Penna	12. CITIZEN OF WHAT COUNTRY? _____
13. FATHER'S NAME Richard Morgans	14. MOTHER'S MAIDEN NAME Mary Morgan		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____	16. SOCIAL SECURITY NO. _____	INFORMANT Albert Stuhr 7710 Phila Road	Address _____
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY THROMBOSIS INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), slotting the under- lying cause last. (b) DUE TO GENERALIZED ARTERIOSCLEROSIS 5 yrs. (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. _____ p. m. _____	Month _____ Day _____ Year 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) _____	(County) _____	(State) _____	
21. I certify that I attended the deceased from MAY 1, 1960 to MAY 3, 1960 that I last saw the deceased alive on May 1, 1960 , and that death occurred at 5 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Emmett P. Davis M.D.			ADDRESS (Street, city or town, state) 5317 BELAIR RD 5/5/60
DATE SIGNED BALTIMORE 6, MD.			
22a. BUR AL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF May 6/60	22c. NAME OF CEMETERY OR CREMATORIAL Meadow Ridge
22d. LOCATION (City, town, or county) Howard County		(State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road		24a. REC'D BY REGISTRAR Chilius S. Kraus	24b. REGISTRAR'S SIGNATURE Chilius S. Kraus



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05534

Reg. Dist. No.

5395

1. PLACE OF DEATH
a. COUNTY

BALTIMORE

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE

MD

b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL
and give nearest town)

DUNDALK

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

BALTIMORE 23

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

WILLIAM HARTS-OLD North Point Rd

d. STREET ADDRESS

1337 Ramsay St

e. IS RESIDENCE
ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

First: William
Middle: VINCENT
Last: SNETA

4. DATE
OF
DEATH

Month: MAY
Day: 20
Year: 1960

5. SEX

MALE

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

31 May 1906

9. AGE (In years
last birthday)

53 yrs.

10. IF UNDER 1 YEAR

Months: 0
Days: 0

11. IF UNDER 24 HRS.

Hours: 0
Min: 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Spot Welder

10b. KIND OF BUSINESS OR INDUSTRY

Stove Mfg

11. BIRTHPLACE (State or foreign country)

PENNA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

VINCENT SNETA

14. MOTHER'S MAIDEN NAME

JOSEPHINE Budrevic

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

YES

If yes, give war or dates of service

WW2

16. SOCIAL SECURITY NO.

107-05-0008

17. INFORMANT

VICTOR W. SNETA 749 E. 37th St. Baltimore 18 MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420-1

DUE TO

(b)

Hyperension, Coronary Occlusion

INTERVAL BETWEEN
ONSET AND DEATH

2 min

DUE TO

(c)

Hyperension, Cardiovascular D.s.

3 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour

o. m.

p. m.

19

While
at work

Not while
at work

20d. INJURY OCCURRED

While
at work

Not while
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

JACK C. COLLINS

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

5-26-60

22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

14 May 1960

22c. NAME OF CEMETERY OR CREMATORIUM

BALTIMORE NATIONAL CEM.

22d. LOCATION (City, town, or county)
(State)

BALTIMORE

24a. REC'D BY REGISTRAR

MAY 23 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. Kline

TO DIRECT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Fill in Item 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55



14
FDR STATE
HEALTH DEPT.

M

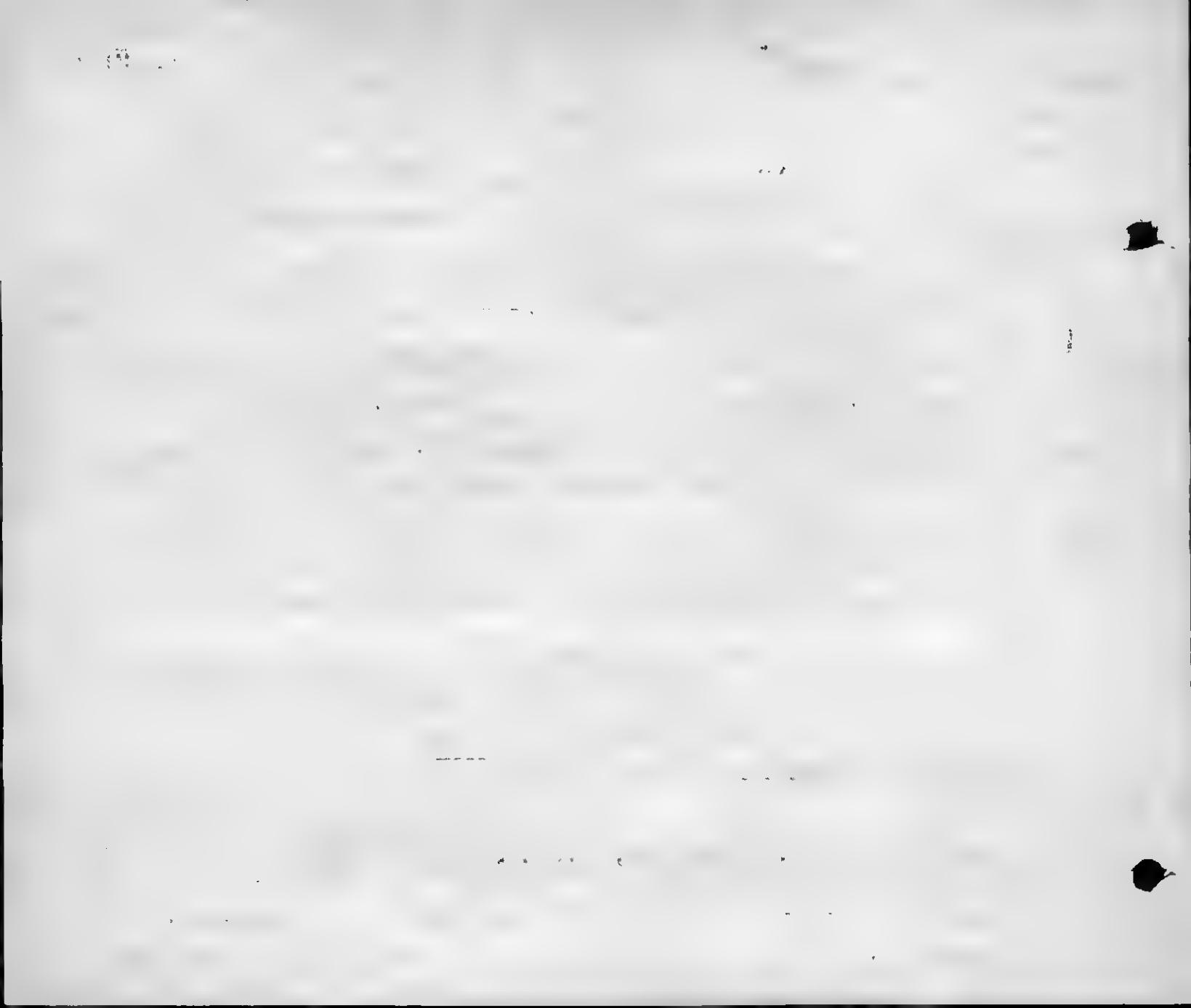
TO DELIVER MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05535

1. PLACE OF DEATH e. COUNTY	5563 Baltimore	MARYLAND c. LENGTH OF STAY IN lb	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) e. STATE Maryland b. COUNTY Bal timore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 40, Allender Road		d. STREET ADDRESS Route 40, Allender Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print)	First JOHN William	Middle SWEENEY	4. DATE OF DEATH May 16 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-2-1923	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Traffic Analyst	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 36 yrs.	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Patrick J. Sweeney	14. MOTHER'S MAIDEN NAME Sarah A. Brogan	15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give war or peacetime service) yes UW 2	16. SOCIAL SECURITY NO.	17. INFORMANT Marjorie A. Sweeney
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease		Address same		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH		
DUE TO (b)				
DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or Town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>TDK</i>				
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D.				
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
DATE SIGNED 5/17/60				
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 5-19-60	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Baltimore National	22d. LOCATION (City, town, or country) Baltimore, Md.	(State)
23. FUNERAL DIRECTOR Leonard J. Ruck 5305 Harford Rd.	24a. REC'D BY REGISTRAR DATE MAY 19 '60	24b. REGISTRAR'S SIGNATURE <i>Charles S. Kline</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 14 & 22b Film G263 5/10/60 iwk

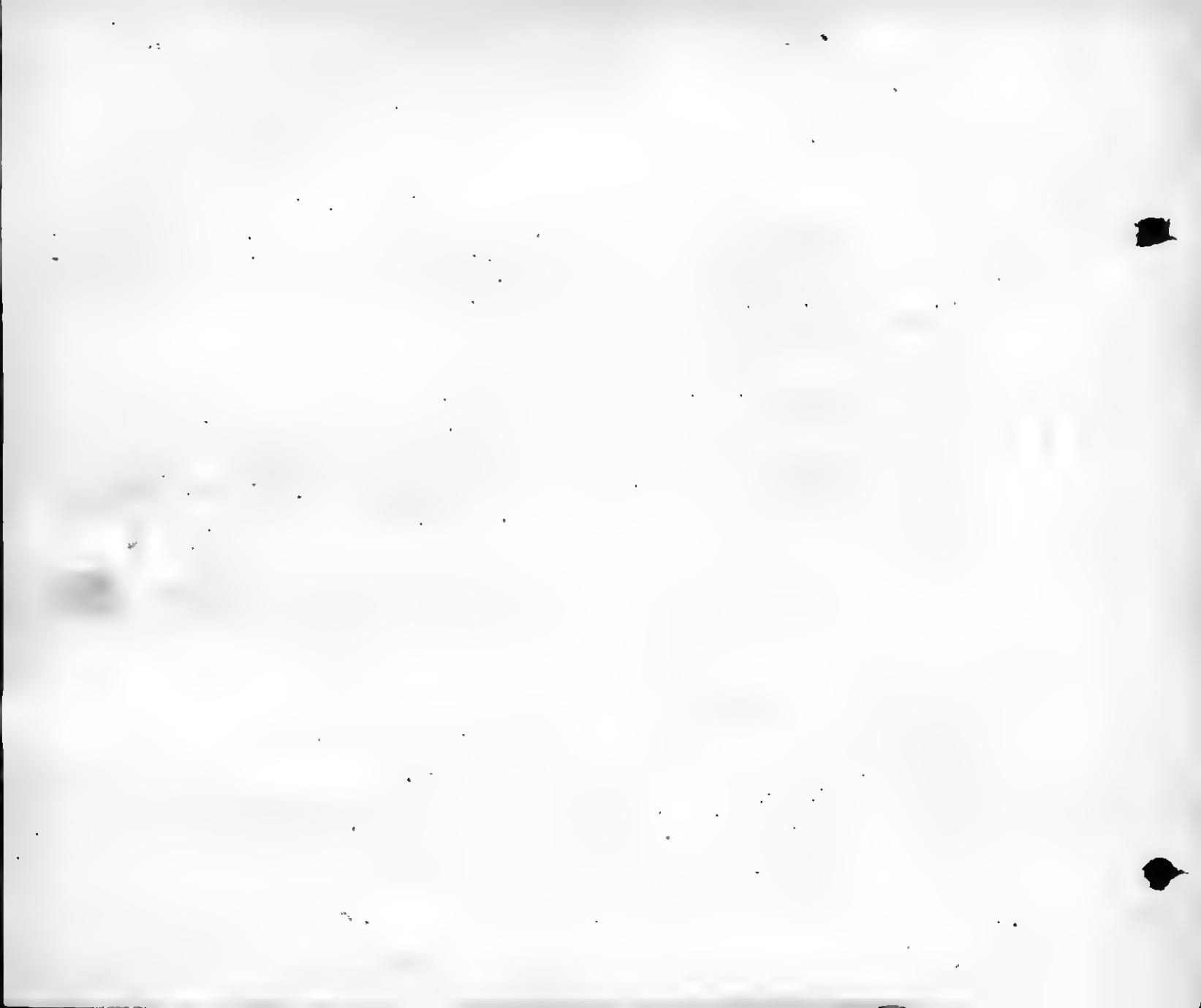
05536

5564

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Baltimore County Catonsville MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		a. STATE Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Summit Nursing Home Smithwood Dr.		Baltimore		14	
3. NAME OF DECEASED (Type or print)		First Peter	Middle	4. DATE OF DEATH	Month 5 - 10 - 1960 Day Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	8. AGE (In years lost birthday). yrs.
Male		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1896 5/12/1897	12 months 63
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Baltimore	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John Dzynanska		Mighalina		unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown)		16. SOCIAL SECURITY NO.		INFORMANT	
No		IN		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Chronic Brain Syndrome associated with Arterio sclerosis.			
527.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Arteriosclerotic Heart Disease			
DUE TO (b)		Senile Encephalitis			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19		July 1958		5/10/60	
21. I certify that I attended the deceased from _____ alive on _____		that I last saw the deceased 5/9/60, 19, and that death occurred at 1:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W.E. McGrath		ADDRESS (Street, city or town, state) 1303 Frederick Rd Catonsville 28 Md DATE SIGNED 5/11/60			
PHYSICIAN'S NAME (Type)		M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22d. LOCATION (City, town, or county) (State)	
Burial		May 14, 1960		St. Stanislaus Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. ADDRESS		24b. REC'D BY REGISTRAR	
Fred W. Ozarewski		1930 Eastern Av		MAY 12 '60	
VS A15 (4) ISM 9/58		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			





TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

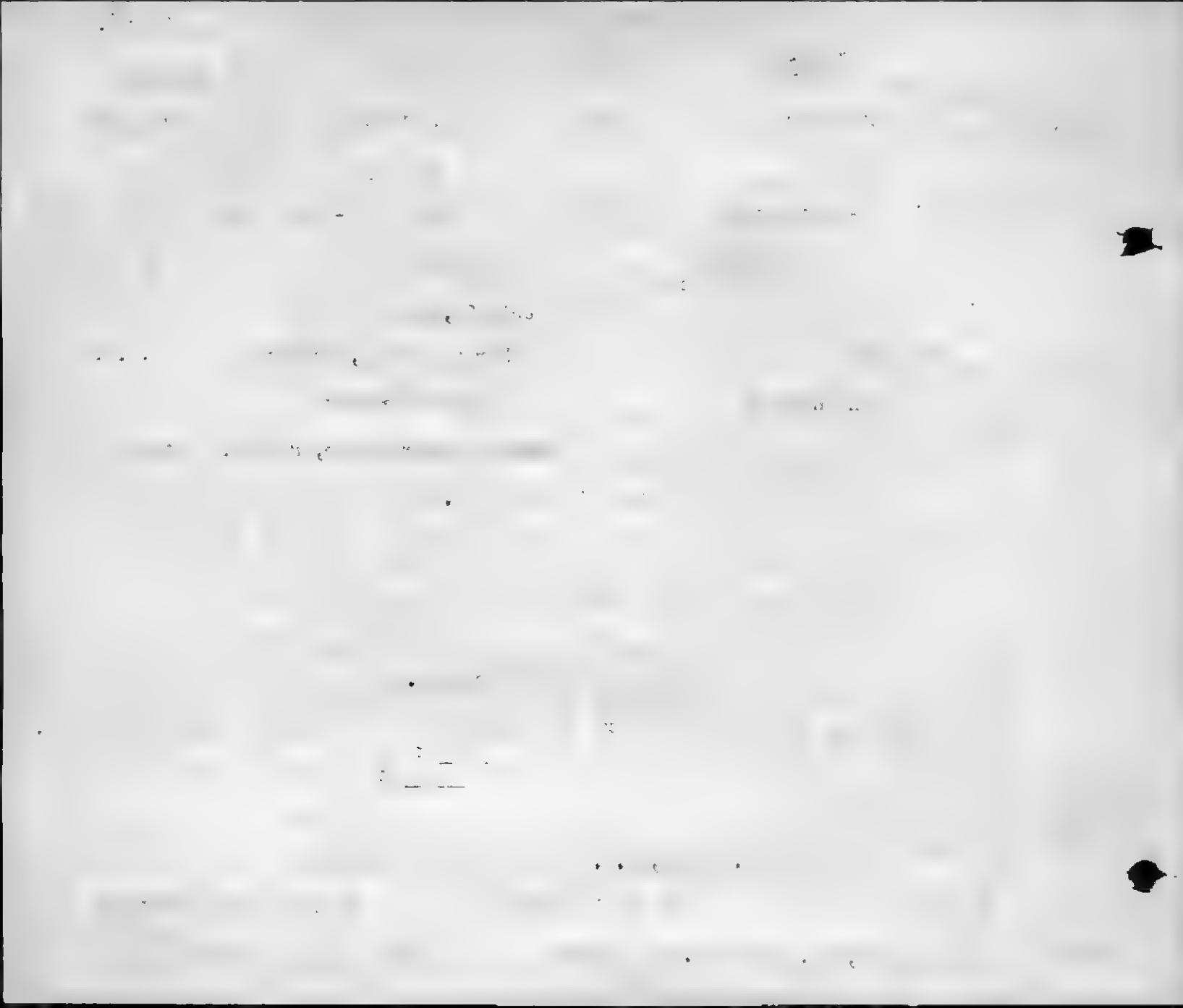
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

539 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05537

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)	
a. COUNTY		a. STATE	
Baltimore		Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Dundalk		Baltimore	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
8000 Mid-Haven Road		8000 Mid-Haven Road	
3. NAME OF DECEASED (Type or print)		First	Middle
BEATRICE			
4. SEX		5. COLOR OR RACE	
Female		White	
6. MARRIED		NEVER MARRIED	<input type="checkbox"/>
WIDOWED		<input type="checkbox"/>	DIVORCED
7. DATE OF BIRTH		8. DATE OF DEATH	
July 22, 1925		May 30 1960	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Sheppard		Lizzie Hensley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give award dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT	
		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Stab Wound of Left Chest.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	
DUE TO		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED?	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. xxx May 30 1960		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Home		Dundalk Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <i>Charles S. Petty.</i>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		DATE SIGNED 5/31/60	
REMOVAL		22b. DATE THEREOF 6-1-60	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or country) (State)	
Stanfill Cemetery		Harlan County, Kentucky	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR JUN 1 '60	
William Cook, Inc., 1217 St. Paul Street		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 M1m-204 6-6-60 et

05538

5565

CERTIFICATE OF DEATH

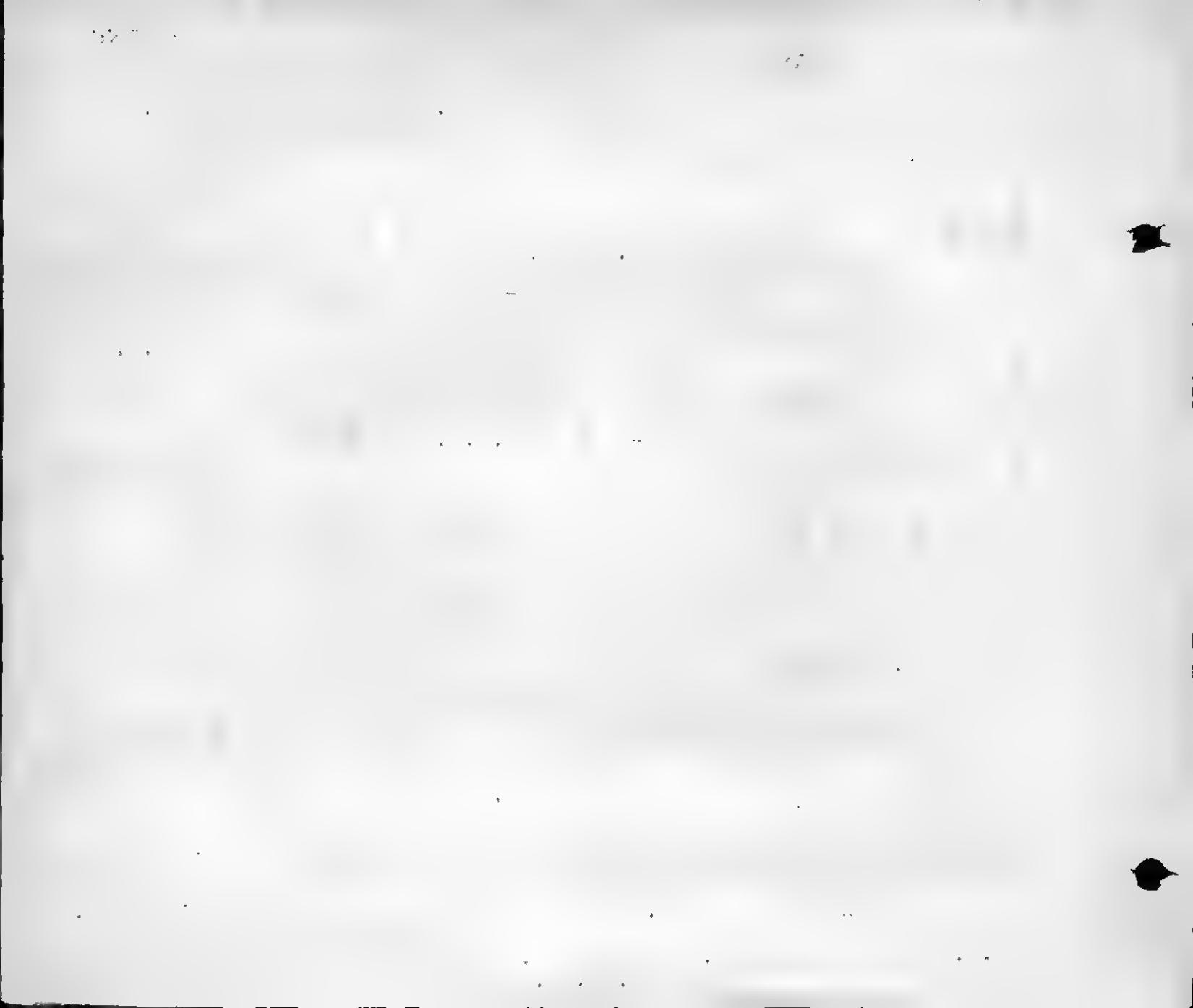
Items 8, 9 M1m-204 6-6-60 et

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Garrison		d. STREET ADDRESS Valley Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Valley Road						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John		First G.	Middle Thomas	Lost	4. DATE OF DEATH May 31 1960	Month May	Day 31	Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-3-1893 1883	9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. Months 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Banking		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME John Marshall Thomas		14. MOTHER'S MAIDEN NAME Anne Campbell Gregg							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) Yes		16. SOCIAL SECURITY NO. WW 1 215-18-2061		17. INFORMANT A Mrs. J. T. Barthel		Address Above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first (b) DUE TO (c) <i>Arterio - sclerosis</i>				<i>Cardio - vascular Rival disease</i>		INTERVAL BETWEEN ONSET AND DEATH 18 months			
				<i>arterio - sclerosis</i>		5 years			
				<i>Arterio - sclerosis</i>		5 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.		20f. (City or town) 1725 Reservoir Rd.		(County) Baltimore	(State) Md.
21. I certify that I attended the deceased from <i>May 16, 1960</i> to <i>May 31, 1960</i> , that I last saw the deceased alive on <i>May 31, 1960</i> , and that death occurred at <i>99 M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>1725 Reservoir Rd. Baltimore 8. Md.</i>							DATE SIGNED <i>June 6, 60</i>
ACTUAL SIGNATURE <i>Palmer F. C. Williams</i>									
PHYSICIAN'S NAME (Type) <i>Palmer F. C. Williams</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-2-1960		22c. NAME OF CEMETERY OR CREMATORIAL St. Thomas'		22d. LOCATION (City, town, or county) Garrison Forest		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H.W.Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. 12, Md.		24a. REC'D BY REGISTRAR JUN 2 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>			
VS A15 (4) 15M 9/35									



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item #3-FilmG262-5/10/60-rgb

5565

CERTIFICATE OF DEATH

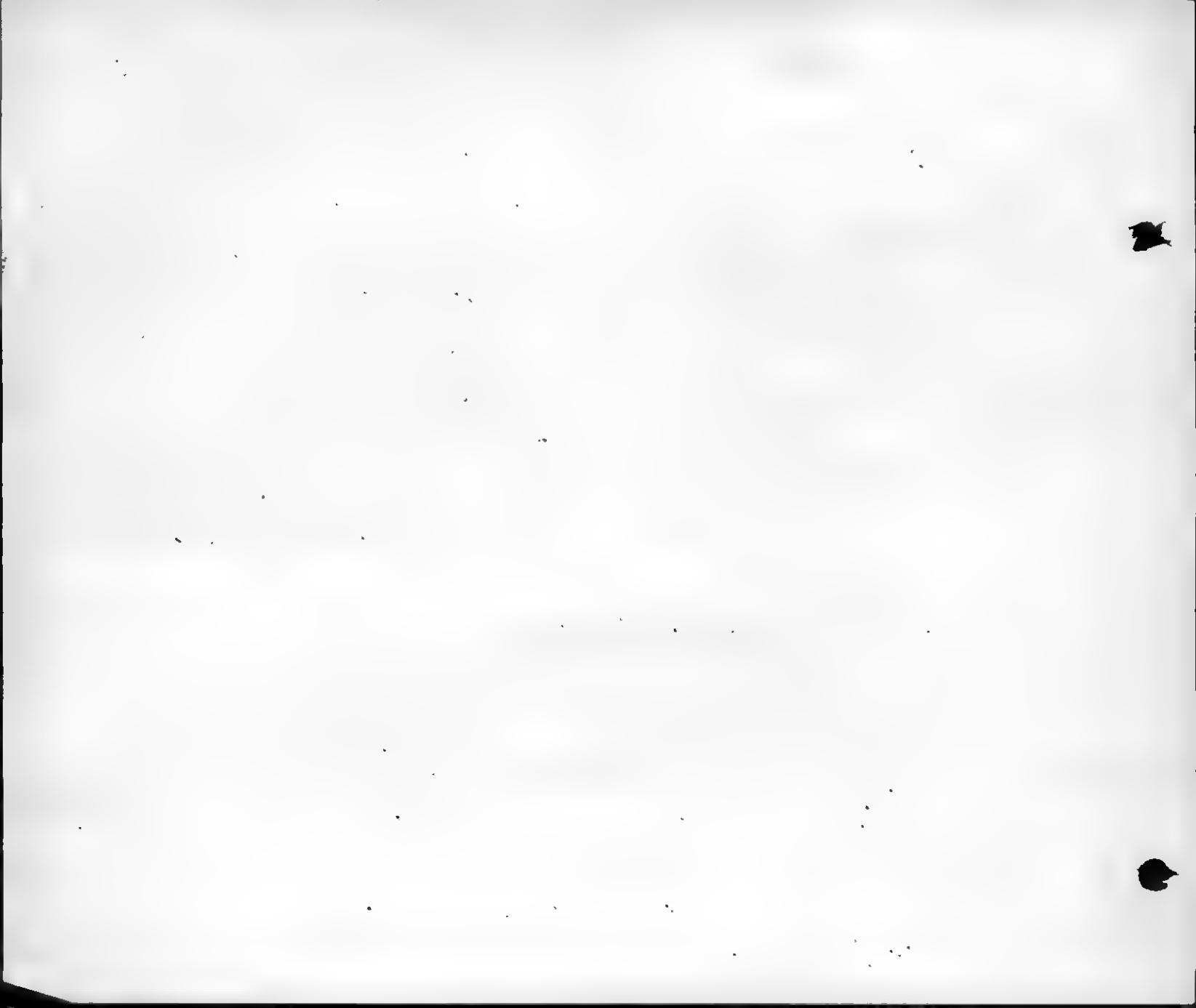
05539

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>45 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6601 Kenwood Ave.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. STREET ADDRESS <i>6601 Kenwood Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>(JACK) HERSEY</i>	First <i>F.</i>	Middle <i>Thompson</i>	Last 4. DATE OF DEATH <i>May 3 1960</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-25-1899</i>
9. AGE (In years last birthday) <i>60 yrs</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Welder</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Penna. R.R.</i>	12. BIRTHPLACE (State or foreign country) <i>Virginia</i>
13. FATHER'S NAME <i>Thomas Thompson</i>	14. MOTHER'S MAIDEN NAME <i>Serra (Unknown)</i>	15. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	17. SOCIAL SECURITY NO. <i>WWI</i>	18. INFORMANT <i>Rose E. Thompson</i>	19. Address <i>6601 Kenwood Ave.</i>
B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. DUE TO <i>[]</i> DUE TO <i>[]</i> DUE TO <i>[]</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Amputated Rt leg</i>			
20a. ACCIDENT OR UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>1960</i>	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June 1, 1960</i> to <i>May 3, 1960</i> that I last saw the deceased alive on <i>May 3, 1960</i> and that death occurred at <i>4 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John Bannigan, M.D.</i>		ADDRESS (Street, city or town, state) <i>Baltimore, Md.</i>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <i>5/4/60</i>	
22a. BUR. A., CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>5-6-60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore Nat'l Cem.</i>
22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sassahn Fam'l Home, 7401 Belair Rd.</i>		24a. ADDRESS <i>7401 Belair Rd.</i>	24b. REGISTRAR'S SIGNATURE <i>Charles S. Evans</i>
24c. REC'D BY REGISTRAR DATE <i>MAY 6 '60</i>			



55 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

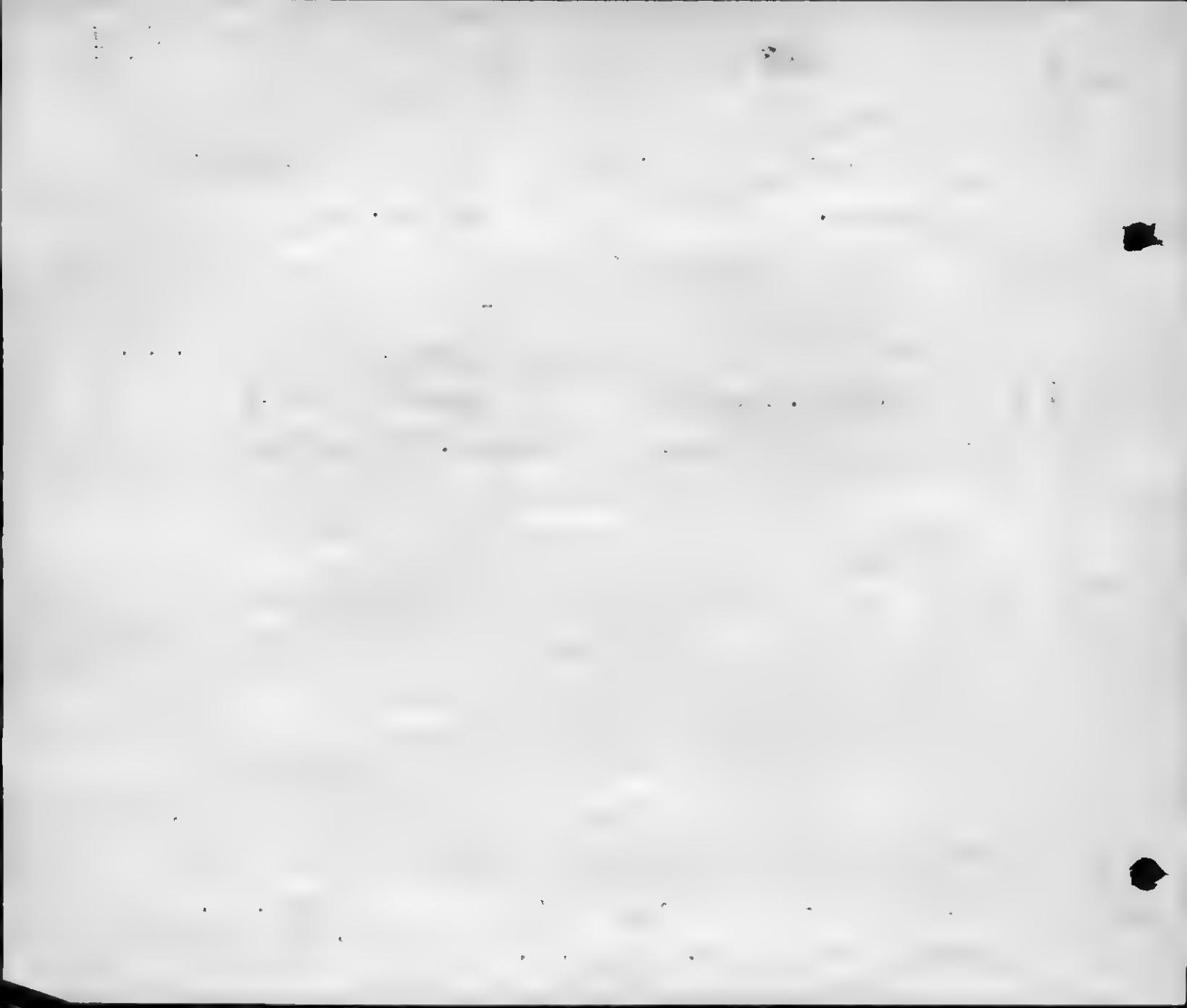
15540

FOR STATE
HEALTH DEPT.

TO DELAY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland	b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville	c. LENGTH OF STAY IN 1b life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Texas	d. STREET ADDRESS York Rd.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) York Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) THOMAS Lewis	First	Middle	4. DATE OF DEATH May 13, 1960				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	5. DATE OF BIRTH 3-20-58				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Maryland	9. AGE (In years last birthday) 2 yrs.				
13. FATHER'S NAME Thomas A. Thompson	14. MOTHER'S MAIDEN NAME Gladys Cornett	12. CITIZEN OF WHAT COUNTRY? U.S.A.	10. IF UNDER 1 YEAR Months Days Hours Min. 11. IF UNDER 24 HRS. Hours Min.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or date of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Thomas A. Thompson	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 881.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO	19. INTERVAL BETWEEN ONSET AND DEATH above			
20a. EXTERNAL CAUSE WAS PR.MARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ingested and aspirated lighter fluid	20c. TIME OF INJURY 12:00 p.m. 5/13 1960	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bldg., etc.) Home	20f. (City or town) Texas	20g. (County) Balto.	20h. (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D.	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED May 13, 1960			
ACTUAL SIGNATURE 	EXAMINER'S NAME (Type)	Address (Street, city, town, or county) Towson 4, Md.	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-14-60	22c. NAME OF CEMETERY OR CREMATORIAL Prospect Hill	22d. LOCATION (City, town, or country) Towson 4, Md.	
VS. A15ME 5M 7/59	23. FUNERAL DIRECTOR Brooks Funeral Service, Towson 4, Md.	ADDRESS	24a. REC'D BY REGISTRAR MAY 18 '60	24b. REGISTRAR'S SIGNATURE Arthur J. Yocum			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5568

CERTIFICATE OF DEATH

05541

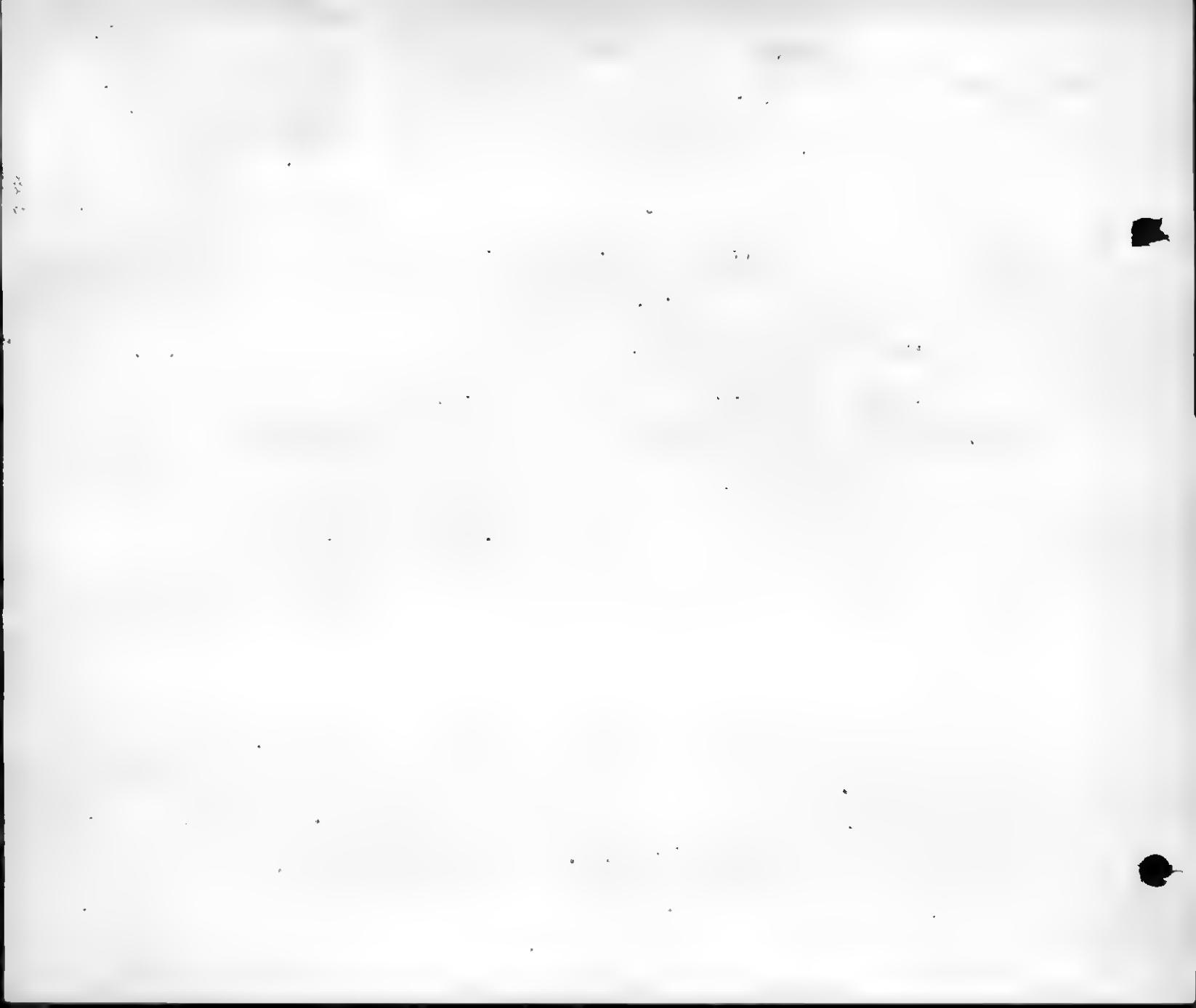
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1mtn28dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant, Md.	
d. STREET ADDRESS 213 Addison Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Joseph	Middle C.	Last Tippett
4. DATE OF DEATH May 2 1960	Month	Day	Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1880
9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXX Retired truck-farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME XXXXXX John Tippett	14. MOTHER'S MAIDEN NAME Unknown	INFORMANT Records: SPRING GROVE STATE HOSPITAL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown XXXXXX No	16. SOCIAL SECURITY NO. 218-10-0364	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY; (IMMEDIATE CAUSE (a)) 422.1 Acute cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 1, 1960, to May 2, 1960, that I last saw the deceased alive on May 2, 1960, and that death occurred at 6:00 a.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. SPRING GROVE STATE HOSPITAL DATE SIGNED 5-2-60			
ACTUAL SIGNATURE <i>Aristides Simopoulos</i>	PHYSICIAN'S NAME (Type) Aristides Simopoulos, M. D.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-5-60	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons	ADDRESS Hyattsville, Md.	24a. REC'D BY REGISTRAR DATE MAY 6 '60	24b. REGISTRAR'S SIGNATURE <i>Cathleen J. Haas</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58



1

FOR STATE
HEALTH DEPT.

TO DELIVER MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, line 1, 2, and 3, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 1 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

18 Film 264 6-10

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

55 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY
Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson

c. LENGTH OF STAY IN 1b
1 yr. 2 mos.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Eudowood Sanatorium

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE
Maryland

b. COUNTY
Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural

d. STREET ADDRESS
221 Preston Ct.,

3. NAME OF
MARY
(Type or print)

First
M

Middle
E. Wagner

Last
TODD

4. DATE
OF
DEATH
May 20 1960

5. SEX
Female

6. COLOR OR RACE
White

7. MARRIED NEVER MARRIED 8. DATE OF BIRTH
1900

9. AGE (In years
last birthday)
59 yrs.

10. IF UNDER 1 YEAR
Months
0

11. IF UNDER 24 HRS.
Hours
0

12. IF UNDER 24 HRS.
Days
0

13. CITIZEN OF WHAT COUNTRY?
U.S.A.

14. MOTHER'S MAIDEN NAME
Estella James

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and dates of service)
16. SOCIAL SECURITY NO. 17. INFORMANT
212-20-8733 **Mrs Robert Rothschild, 560 Graystone Rd.,**
Ambler Pa.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
527.1
DUE TO
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.
(b)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Pulmonary emphysema, bilateral, marked

19. WAS AUTOPSY PERFORMED?
YES NO

20. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.
19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)
(County)
(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE
W. Bradley King, Jr., M.D.

EXAMINER'S NAME (Type)
W. Bradley King, Jr., M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial May 23/60

22b. DATE THEREOF
Springhill Cemetery

22c. NAME OF CEMETERY OR CREMATORIAL
Easton Md.

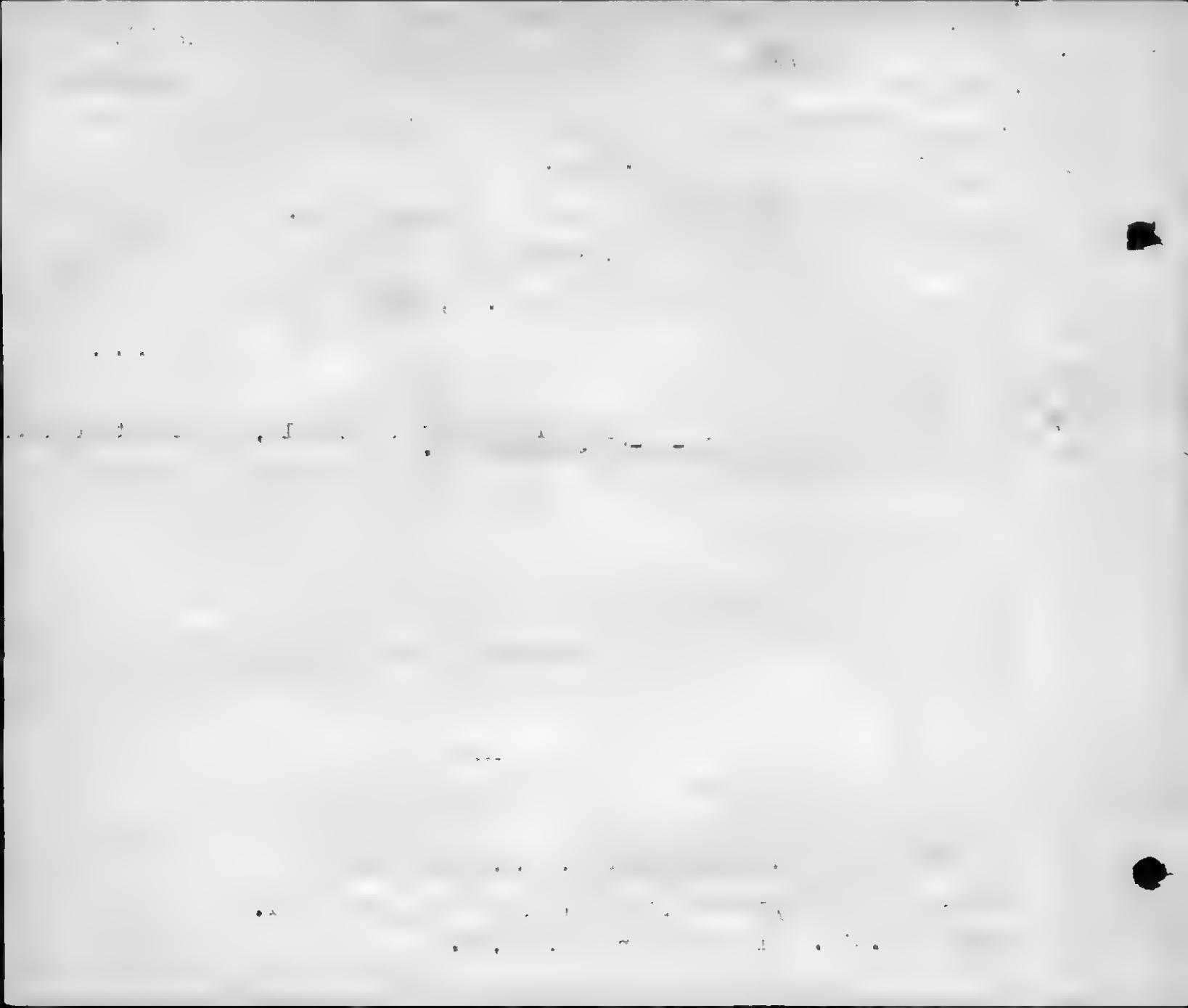
22d. LOCATION (City, town, or county)
(State)

23. FUNERAL DIRECTOR
Witzke Fun. Dir. 4101 Edmondson Ave., #29, Md.

ADDRESS
ADDRESS

24a. REC'D BY REGISTRAR
DATE MAY 24 '60

24b. REGISTRAR'S SIGNATURE
Charles S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

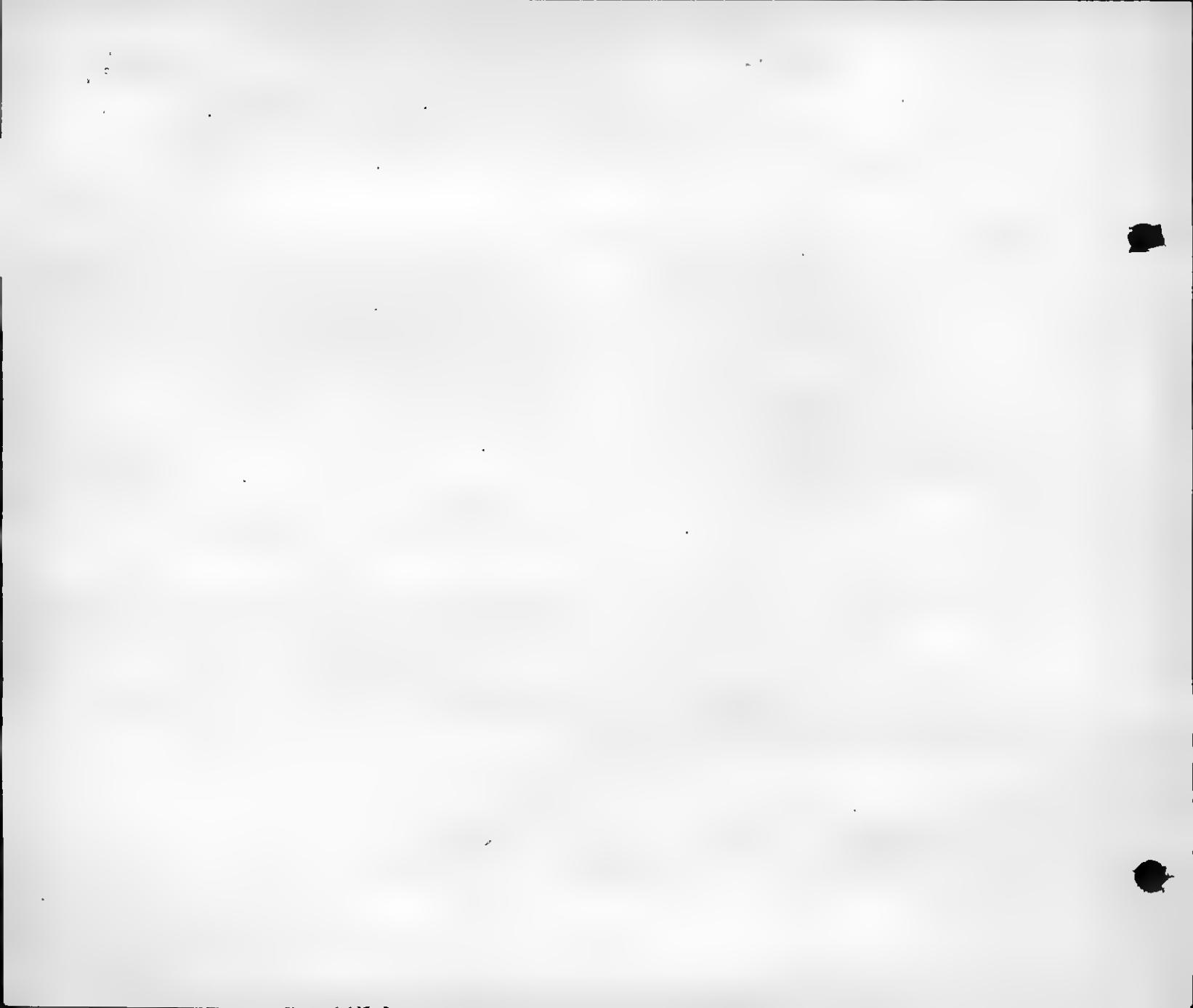
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05543

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ellicott</i>		c. LENGTH OF STAY IN 1b / <i>50 years</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Blanche D. TRAMMELL</i>		First <i>Blanche</i>	Middle <i>D.</i>				
4. DATE OF DEATH <i>MAY 27 1960</i>		Month <i>MAY</i>	Day <i>27</i>				
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
8. DATE OF BIRTH <i>Sept. 28, 1884</i>		9. AGE (In years last birthday) <i>76 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>England</i>				
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Frank Gardner</i>					
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>					
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Myrlie Hammill - Blanche, 46</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>1922.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7</i>					
DUE TO (b) DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>May 29, 1960</i> to <i>May 27, 1960</i> , that (I) (we) last saw the deceased alive on <i>May 26, 1960</i> , and that death occurred on <i>May 27, 1960</i> , from the causes and on the date stated above.		22a. SIGNATURE <i>Tom E. Martin</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>W. M. E. MARTIN</i>		22d. ADDRESS <i>RANDALLSTOWN, MD.</i>					
23a. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5-30-60</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Ellicott Mortician</i>		23d. LOCATION (City, town, or county) <i>Ellicott Mills, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Hight</i>		ADDRESS <i>Glenwood, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>JUN 1 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5571

CERTIFICATE OF DEATH

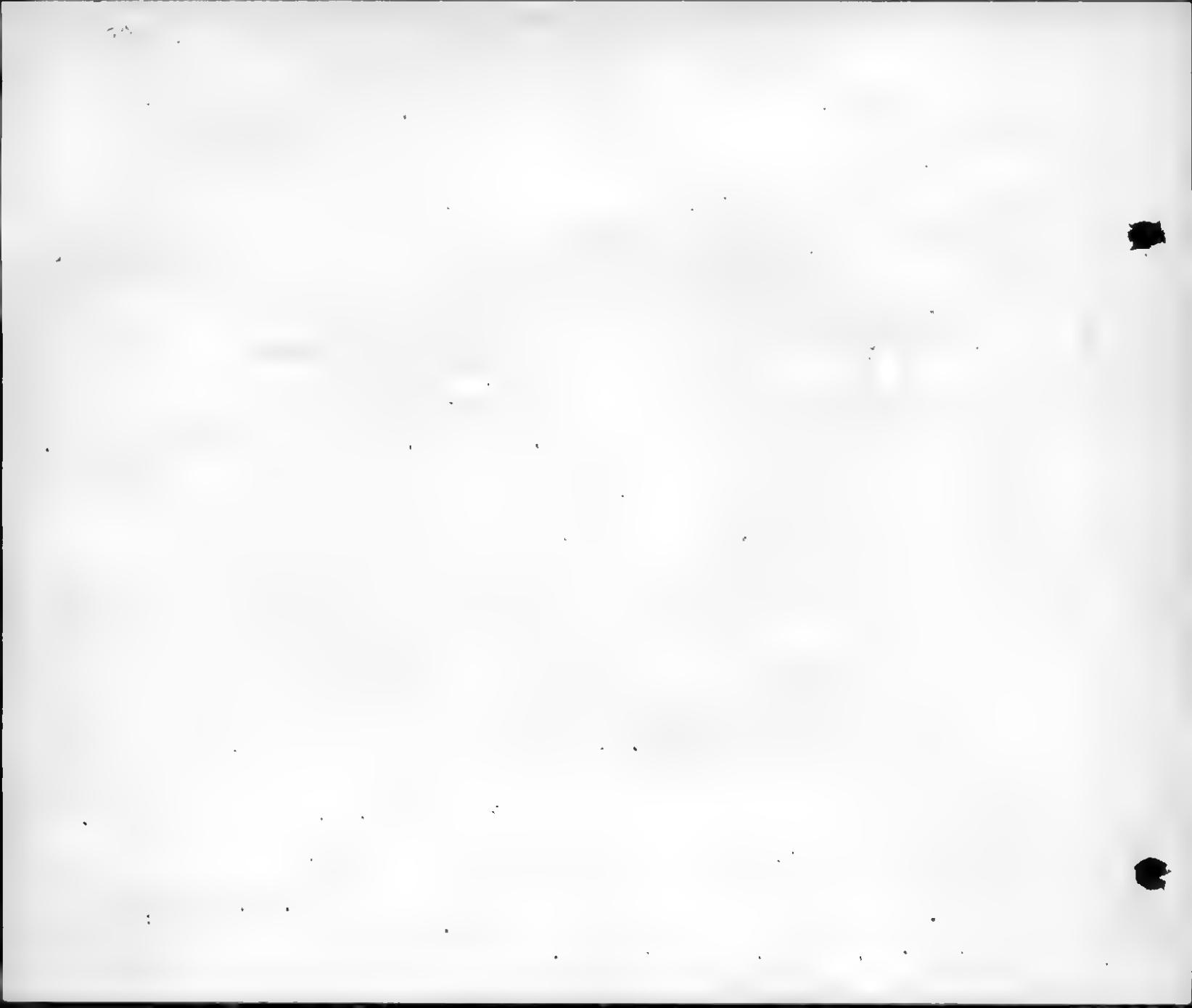
Reg. Dist. No.

05544

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Holly Hill Manor</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Adelia</i>		First <i>Adelia</i>	Middle <i></i>
4. DATE OF DEATH <i>5 8 19 60</i>		5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 5, 1884</i>	
9. AGE (In years last birthday) <i>76 yrs</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles Jording</i>		14. MOTHER'S MAIDEN NAME <i>Elise Andra</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. INFORMANT <i>Mr. Louis L. Myers, 3319 Rueckert Ave.</i>	
17. ADDRESS <i></i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO <i>42</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i></i>	
		(b) <i>Hypertensive-arteriosclerotic Cardio-Vascular Disease</i> DUE TO <i></i> (c) <i></i>	
19. INTERVAL BETWEEN ONSET AND DEATH <i>6 weeks</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Mar. 20, 1960</i> , to <i>May 6, 1960</i> , that I last saw the deceased alive on <i>May 6, 1960</i> , and that death occurred at <i>11:27 P.M.</i> from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <i>Loy M. Zimmerman</i>		ADDRESS (Street, city or town, state) <i>3202 Harford Rd.</i>	
PHYSICIAN'S NAME (Type) <i>Loy M. Zimmerman M.D.</i>		DATE SIGNED <i>5/9/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/11/60</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Western Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 10 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Orlina S. Krause</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5572

CERTIFICATE OF DEATH

05545

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Baltimore MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)

a. STATE

Md

b. COUNTY

Baltimore

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

1408 Spring Avenue

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Rosedale

d. STREET ADDRESS

1408 Spring Ave

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

1884

9. AGE (In years
at birthday)

75

10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Female

WIDOWED DIVORCED

Nov 18 1885

75

yrs

Months

Days

Hours

Min.

13. FATHER'S NAME

Heyman

14. MOTHER'S MAIDEN NAME

Ella Hiner

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unknown)
(If yes, give war & dates of service)

No

16. SOCIAL SECURITY NO.

INFORMANT

Address

Mrs. Walter Turner 1408 Spring

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

Cancer of the breast operated

17

DUE TO

Pt of Dr Goodmann

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

3400 E Baltimore St, Baltimore

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.20d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased
alive on _____, 19_____, and that death occurred at _____ P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Dr. J. Geldrich

M.D.

PHYSICIAN'S
NAME (Type)

Dr. John Geldrich

8019 Philadelphia Rd.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIAL

22d. LOCATION (City, town, or county)

(State)

Removal Jan 3/60

Richland Cem

Johnstown Pa

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

JUN 2 '60

24b. REGISTRAR'S SIGNATURE

Arthur E. Hause



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 230, Form 5573, 7-10-60, iwk

05546

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN TB 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (28)					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 809 Edmondson Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EDWARD		First S	Middle VAETH	4. DATE OF DEATH May	Month	Day	Year 8 1960		
S SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) 63	10. IF UNDER 1 YEAR Months 63	11. IF UNDER 24 HRS Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Automobiles		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME George F. Vaeth				14. MOTHER'S MAIDEN NAME Sophia Nengle					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 215-10-4873		17. INFORMANT Clin. Rec., VAH, Balto. 18, Md. Ft. Howard Division		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EMPYEMA, LEFT LUNG				INTERVAL BETWEEN ONSET AND DEATH 3 DAYS					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) BRONCHOPNEUMONIA				3 DAYS					
(c) SPLENITIS				UNKNOWN					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) BALTIMORE	(County) BALTIMORE	(State) MD
21. I certify that (X) (this hospital) attended the deceased from May 7 1960 to May 8 1960 that (X) (we) last saw the deceased alive on May 8 1960, and that death occurred at 9:40 PM from the causes and on the date stated above.									
22a. SIGNATURE John D. Talbert, M.D.		M.D.		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 5/9/60		
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.		22d. ADDRESS VAH, BALTO. 18, MD. FORT HOWARD DIVISION							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 12, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cemetery		23d. LOCATION (City, town, or county) Baltimore		(State) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Fahey & Sons, 1318 Light St. Balto. Md.		ADDRESS		25a. REC'D BY REGISTRAR John J. Fahey & Sons		25b. REGISTRAR'S SIGNATURE John J. Fahey & Sons			
				DATE MAY 11 '60					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G-63 5/26/60 ikw

5574

CERTIFICATE OF DEATH

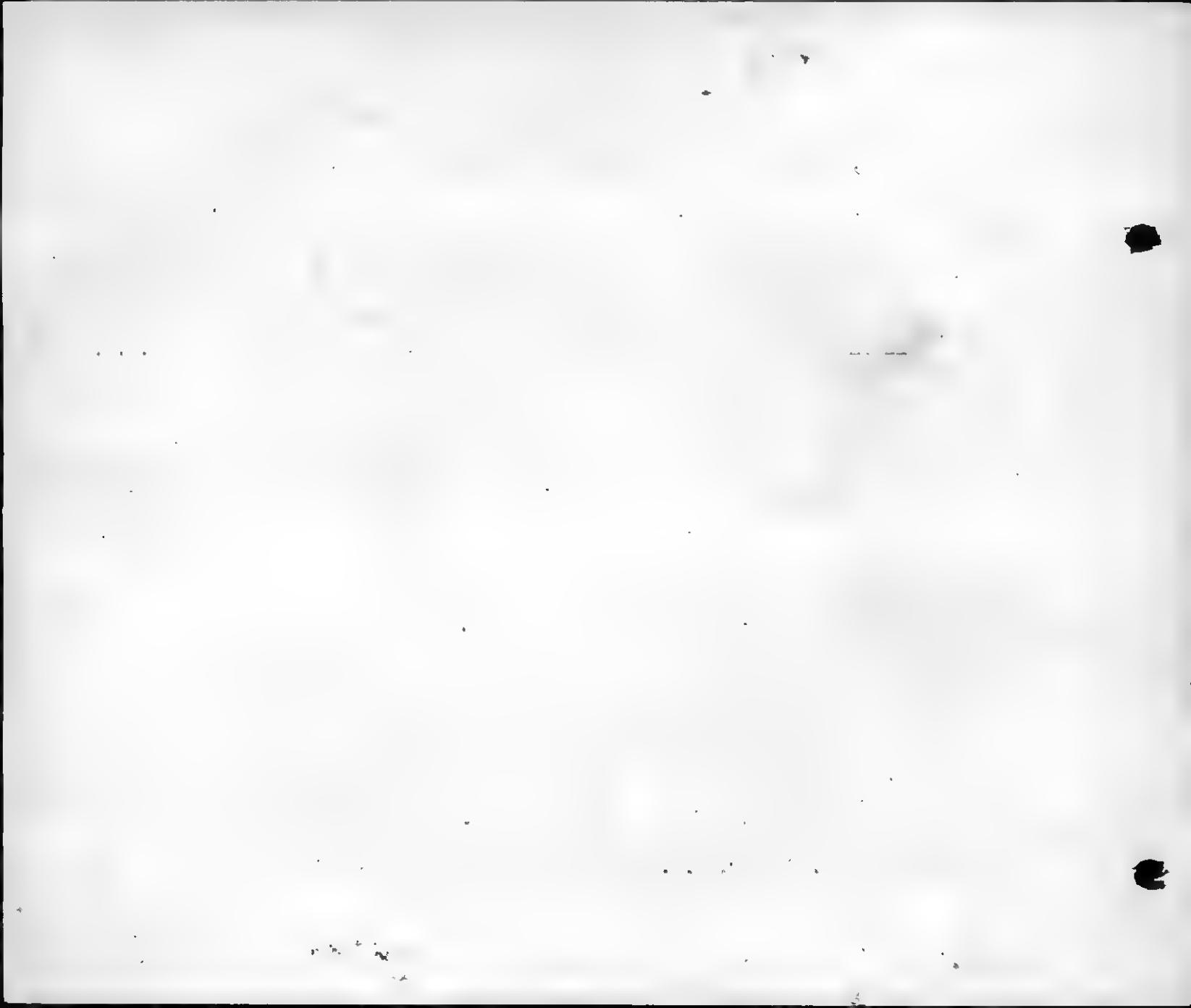
Reg. Dist. No.

05547

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH		Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
a. COUNTY		Maryland		a. STATE Maryland	
Baltimore				b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Owings Mills, Maryland		1½ years		Owings Mills, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?	
Rosewood State Training School		Baltimore, Md.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
		Carrie		Valenski	5
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9/11/88	71 yrs
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Russia	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
?		?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		INFORMANT	
				Spring Grove and Rosewood Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 5-minutes			
Coronary Thrombosis					
DUE TO					
450.1					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b)		Arterio-sclerosis, generalized			
DUE TO		15-years			
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED?			
Imbecile - etiology undetermined - birth.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 12/1/58, 19, to 5/18/60, 19, that I last saw the deceased alive on 5/18/60, 19, and that death occurred at 8:00a.m. from the causes and on the date stated above.					
ADDRESS (Street, city or town, state)					
DATE SIGNED 5/18/60					
ACTUAL SIGNATURE Harry G. Butler, M.D.		Rosewood Training School			
PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.		Owings Mills, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF May 17, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Maryland	
22d. LOCATION (City, town, or county) Baltimore, Md		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Frank A. Denell, Pikesville, Md.		ADDRESS		24a. REC'D BY REGISTRAR MAY 18 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Koenig	



12
FOR STATE
HEALTH DEPT.

M

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with this form. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

557 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

Baltimore

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Sparrows Point

c. LENGTH OF STAY IN 1b

MARYLAND

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

7406 Bay Front Road

Middle

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Sept. 19, 1913

16

9. AGE (In years
at time of
death)

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Steel Worker

10b. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel Co

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph H. Waddell

14. MOTHER'S MAIDEN NAME

Ellen Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

UNKNOWN

Address

Henderson Funeral Home Abingdon, Virginia

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

Cirrhosis.

INTERVAL BETWEEN
ONSET AND DEATH

19. WAS AUTOPSY
PERFORMED?

YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

19

p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion

death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

Charles S. Petty.

CHIEF MEDICAL EXAMINER

M.D.

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

5/27/60

EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Removal

22b. DATE THEREOF

May 28, 1960

22c. NAME OF CEMETERY OR CREMATORI

Saltville Cemetery

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

ADDRESS

William Cook, Inc.

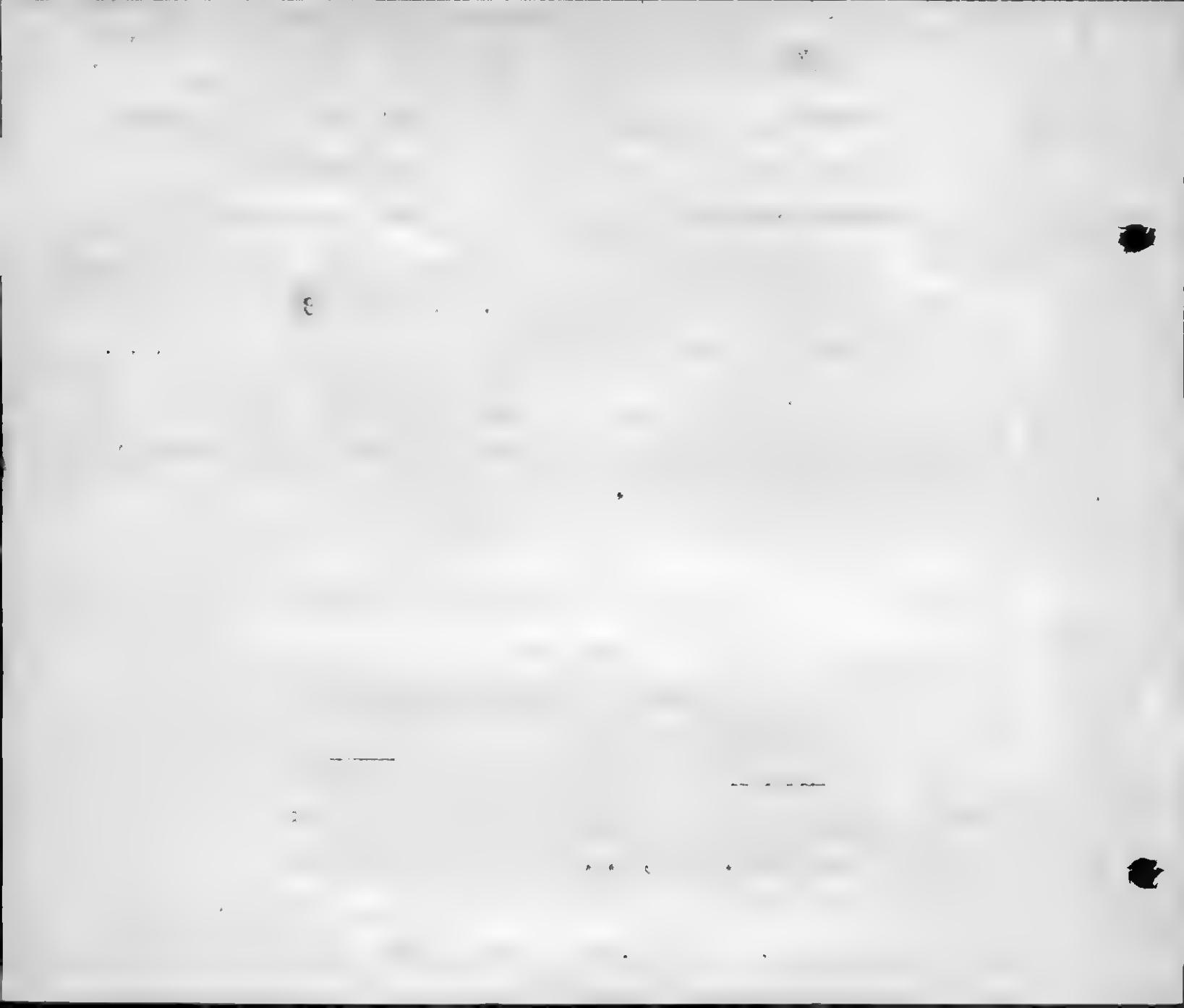
1217 St. Paul Street

24a. REC'D BY REGISTRAR

JUN 1 '60

24b. REGISTRAR'S SIGNATURE

Charles S. Petty



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5576

CERTIFICATE OF DEATH

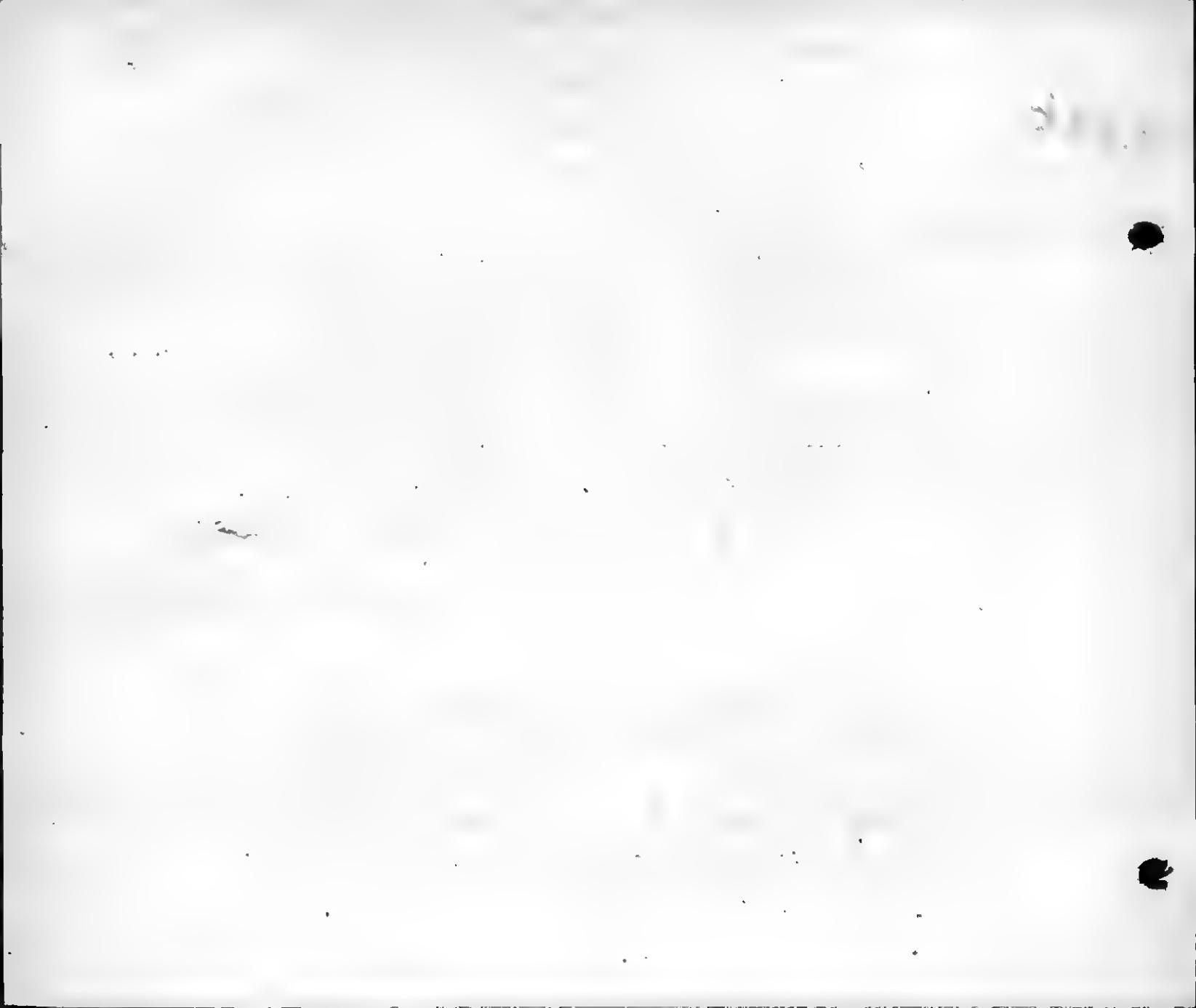
05549

Reg. Dist. No. 4...

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		e. STREET ADDRESS 904 East Pratt Street	
3. NAME OF DECEASED (Type or print) Anna		First Middle May	4. DATE OF DEATH 5
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9/10/29
9. AGE (In years lost birthday) 30	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —	11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Elmer Arthur Wallick		14. MOTHER'S MAIDEN NAME Florence Leonna Brenneman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. —	INFORMANT Rosewood Records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Status epilepticus com-</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>pllicated by Lupus erythematosus.</i> DUE TO (c) <i>taus</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter W. Rieckert	M.D. 4307 Mainfield Ave		ADDRESS (Street, city or town, state) Baltimore 14, Md. DATE SIGNED 5-4-66
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 6-1960	22c. NAME OF CEMETERY OR CREMATORIAL Rosewood cem	22d. LOCATION (City, town, or county) Owings Mills Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE F. Elmer Sons Reston Md	ADDRESS	24a. REC'D BY REGISTRAR DATE MAY 9 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

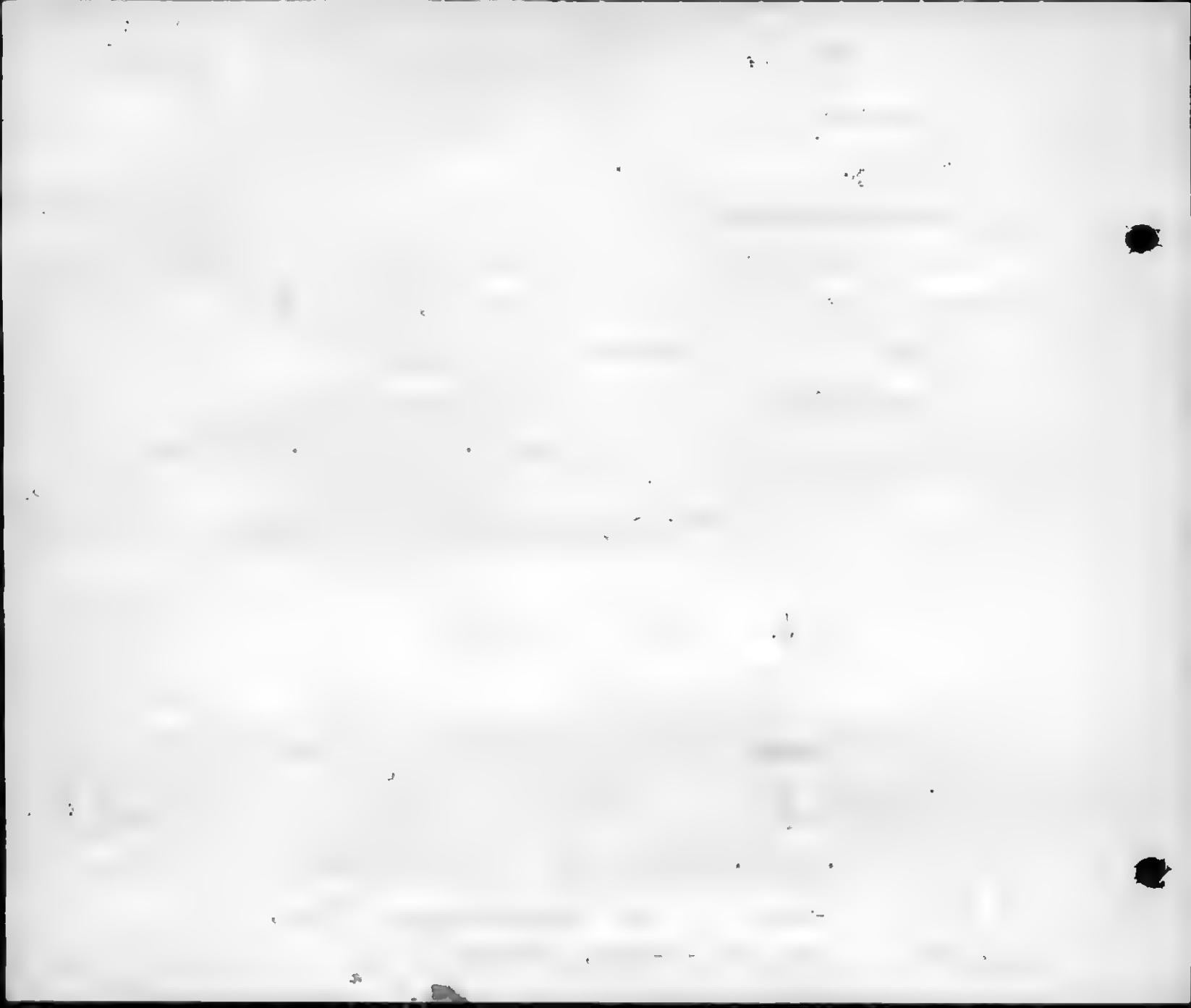
5577

CERTIFICATE OF DEATH

Item 2 Form 264 6-7-60 et

05551

1. PLACE OF DEATH D. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3 mo.		a. STATE Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 29		b. COUNTY	
3. NAME OF DECEASED (Type or print) Marion Louisa Ward		First	Middle	Lost	4. DATE OF DEATH May 28
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH October 7, 1876	Month Year 19 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Silas Whitelock		14. MOTHER'S MAIDEN NAME Lilia Stanford		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Edward S. Ward 7834 St. Bridget Lane 22 NO.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44 C		DUE TO (b) ARTERIOSCHEROTIC CV DISEASE		INTERVAL BETWEEN ONSET AND DEATH 2 HRS.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (c)		DUE TO TROPHIC ULCERS - FEET			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) FEB. 25, 1960, to MAY 28 1960, that (I) (he) last saw the deceased alive on MAY 27 1960, and that death occurred at 2:30 A.M. from the causes and on the date stated above			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Belair	(County) Maryland
21. I certify that (I) (he) attended the deceased from		22b. DATE SIGNED May 30, 1960			
22c. PHYSICIAN'S NAME (Type) Dr. John F. Schaefer		M.D.	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22d. ADDRESS 401 Random Road	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-31-60	23c. NAME OF CEMETERY OR CREMATORIAL Belair Memorial Gardens	23d. LOCATION (City, town, or county) Belair, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell, Havre-de-Grace, Maryland		ADDRESS R. Madison Mitchell, Havre-de-Grace, Maryland		25a. REC'D BY REGISTRAR DATE JUN 1 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus



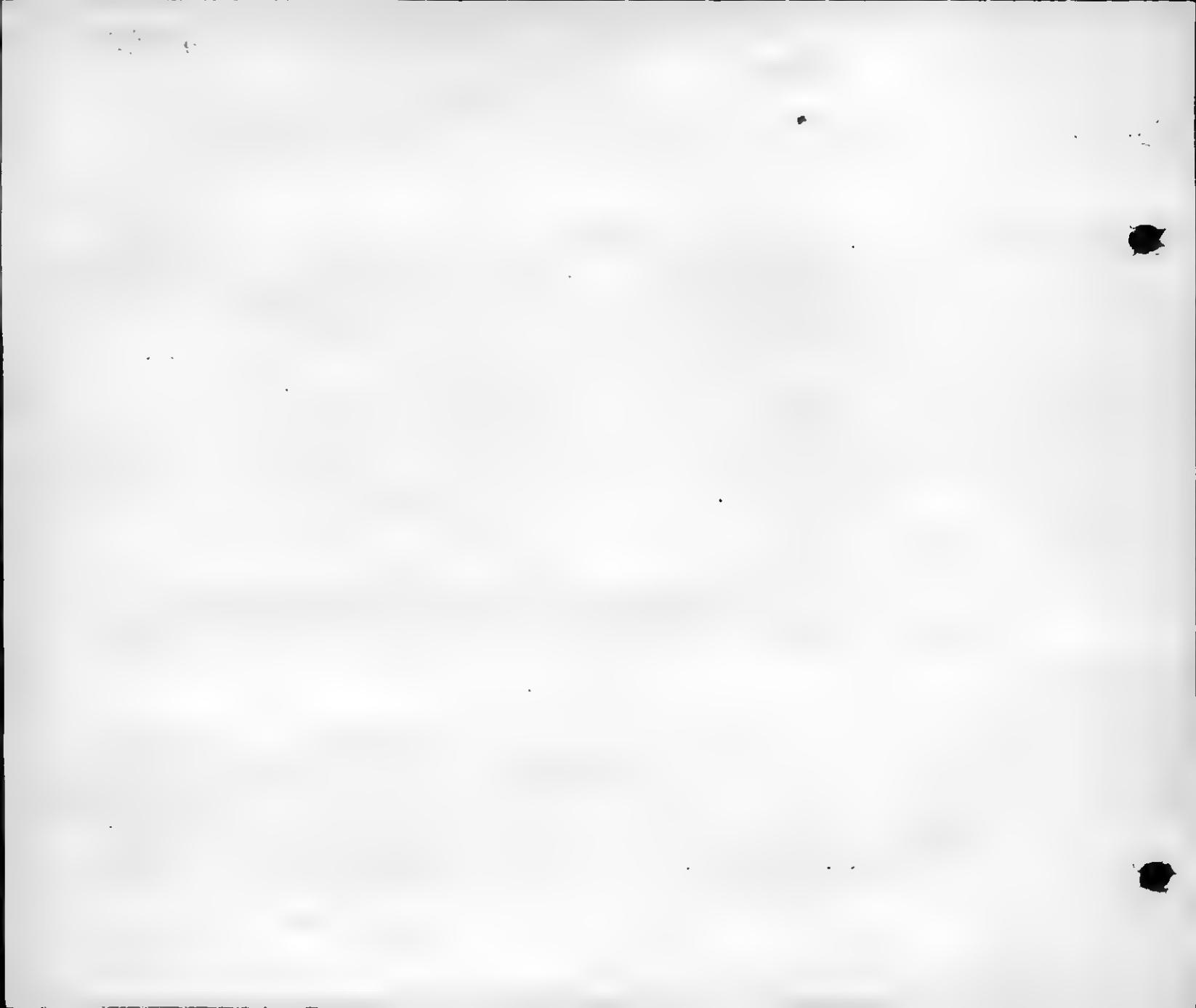
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

05551

5398

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1630 Searles Road		d. STREET ADDRESS 1630 Searles Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First HORATIO	Middle NELSON	Last WARDROPPER
S. SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1901
9. AGE (in years last birthday) 58 yrs		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Steel	11. BIRTHPLACE (State or foreign country) England
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Horatio Wardropper		14. MOTHER'S MAIDEN NAME Isabelle McDonald	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Jessie Wardropper 1630 Searles Road-22
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Accidents - Nov. 10 - 1959 -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 10008	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. (City or town) Colgate, Md.		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from NOV. 79, 1959 to May 9, 1960 , that (I) (we) last saw the deceased alive on May 6, 1960 , and that death occurred at 5 P.M. from the causes and on the date stated above.		22b. DATE SIGNED 5/11/60	
22a. SIGNATURE M. B. Davis, M.D.		22b. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) M. B. Davis, M.D.		22d. ADDRESS 6800 Maryland Ave - Dundalk - Md	
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/12/60	
23c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn Cemetery		23d. LOCATION (City, town, or county) Colgate, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md.		25a. REC'D BY REGISTRAR DATE MAY 12, 1960	
		25b. REGISTRAR'S SIGNATURE John S. Miller	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death: Page 4

by the funeral director, by the funeral director,
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

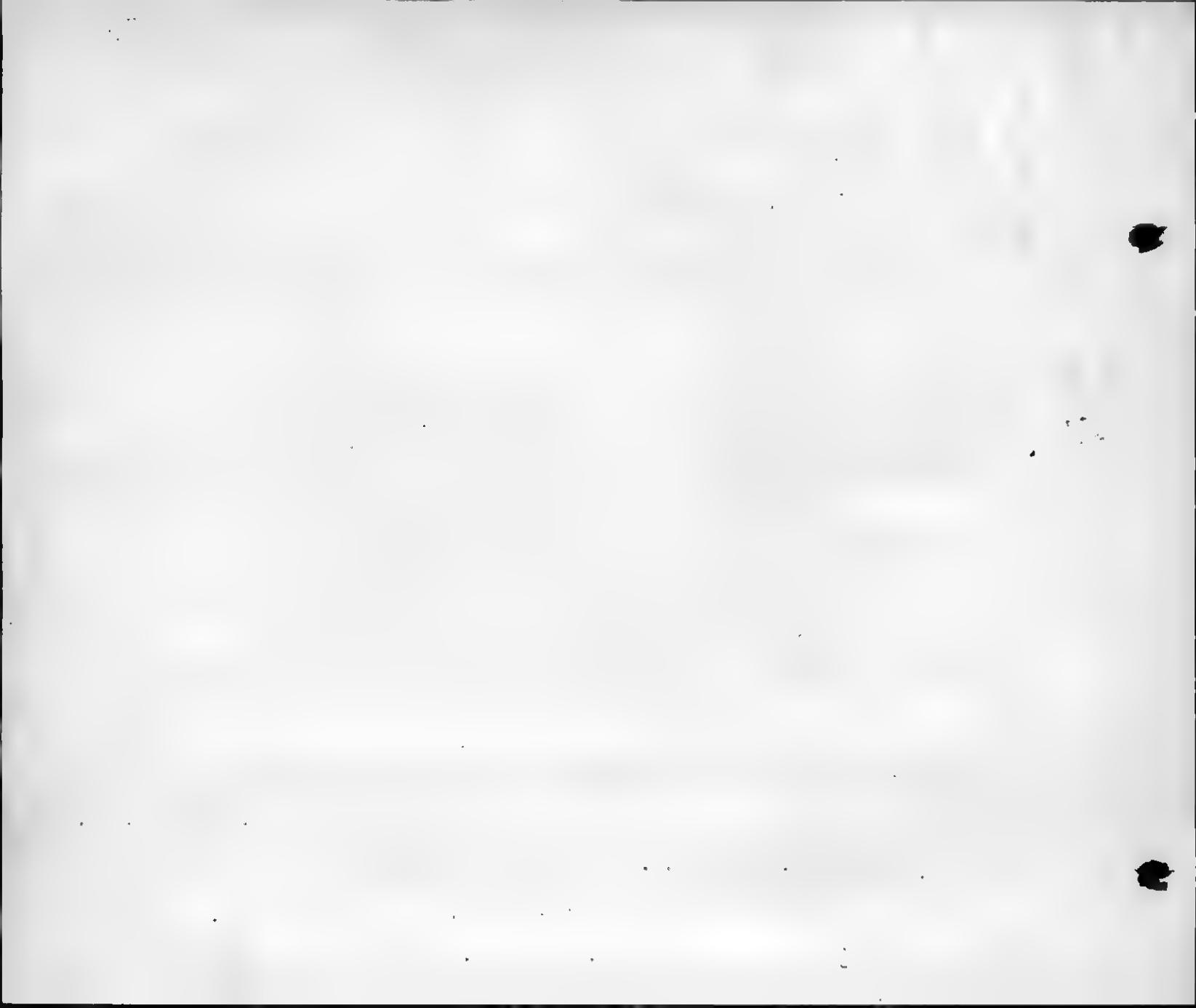
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5578

CERTIFICATE OF DEATH

05552
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md		b. COUNTY None	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 10 E. Hill St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eudowood Sanatorium Tows on 4, Maryland				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Leo	Middle Washenfeldt	4. DATE OF DEATH May 2 1960	Month May	Day 2	Year 1960
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/9/04	9. AGE (In years less birthday) 55 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during time of working life, even if retired) Chandler		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John Washenfeldt		14. MOTHER'S MAIDEN NAME Ellen May					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO.		17. INFORMANT Personal History Address Hospital Records, Eudowood Sanatorium			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH 4 mos DUE TO COPD Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Pulmonary Tuberculosis</u> 14 yrs DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 28, 1960</u> to <u>May 2, 1960</u> that I last saw the deceased alive on <u>May 2, 1960</u> , and that death occurred at <u>10:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Milton B. Kress</u> <u>May 5, 1960</u> PHYSICIAN'S NAME (Type) <u>Milton B. Kress, M.D.</u> Eudowood Sanatorium, Towson 4, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 6 1960		22c. NAME OF CEMETERY OR CREMATORIAL New Cathedral Cem.		22d. LOCATION (City, town, or county) Baltimore Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Delakoe</u>		ADDRESS 322 S. High St.		24a. REC'D BY REGISTRAR DATE MAY 5 '60		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kress</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5579 CERTIFICATE OF DEATH 05553

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Upperco (Rural)</i>		c. LENGTH OF STAY IN 1b <i>5 yrs</i>	
d. NAME OF HOSPITAL (If not in hospito, give street address) OR INSTITUTION <i></i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Upperco - Rural</i>	
e. STREET ADDRESS <i></i>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Norman P. Waugh</i>		4. DATE OF DEATH <i>May 1 1960</i>	Month Day Year
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept 1-1903</i>	
9. WIDOWED <input type="checkbox"/>		10. DIVORCED <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>General</i>	
10c. BIRTHPLACE (State or foreign country) <i>W. Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James B Waugh</i>		14. MOTHER'S MOTHER'S NAME <i>Emma J Duncan</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>W. W.</i>		16. SOCIAL SECURITY NO. <i>234-12-5380</i>	
17. INFORMANT <i>Mrs. Norman Waugh</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <i>540.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Gastric Intestinal Hemorrhage 1 day Reptile ulcer 1 week</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i></i>	
21. I certify that I attended the deceased from <i>April 30, 1960</i> , to <i>May 1, 1960</i> , that I last saw the deceased alive on <i>April 30, 1960</i> , and that death occurred at <i>617 M</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>511/160</i> DATE SIGNED <i>5/1/60</i>			
ACTUAL SIGNATURE <i>W.H. Foard</i>		M.D. <i>511/160</i>	
PHYSICIAN'S NAME (Type) <i>W.H. Foard, M.D.</i>		22. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
22b. DATE THEREOF <i>May 4-60</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Pleasant Grove</i>	
22d. LOCATION (City, town, or county) <i>Balto</i>		(State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edwin S. Tipton - Hampstead Md</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 4 '60</i>	
ADDRESS <i></i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

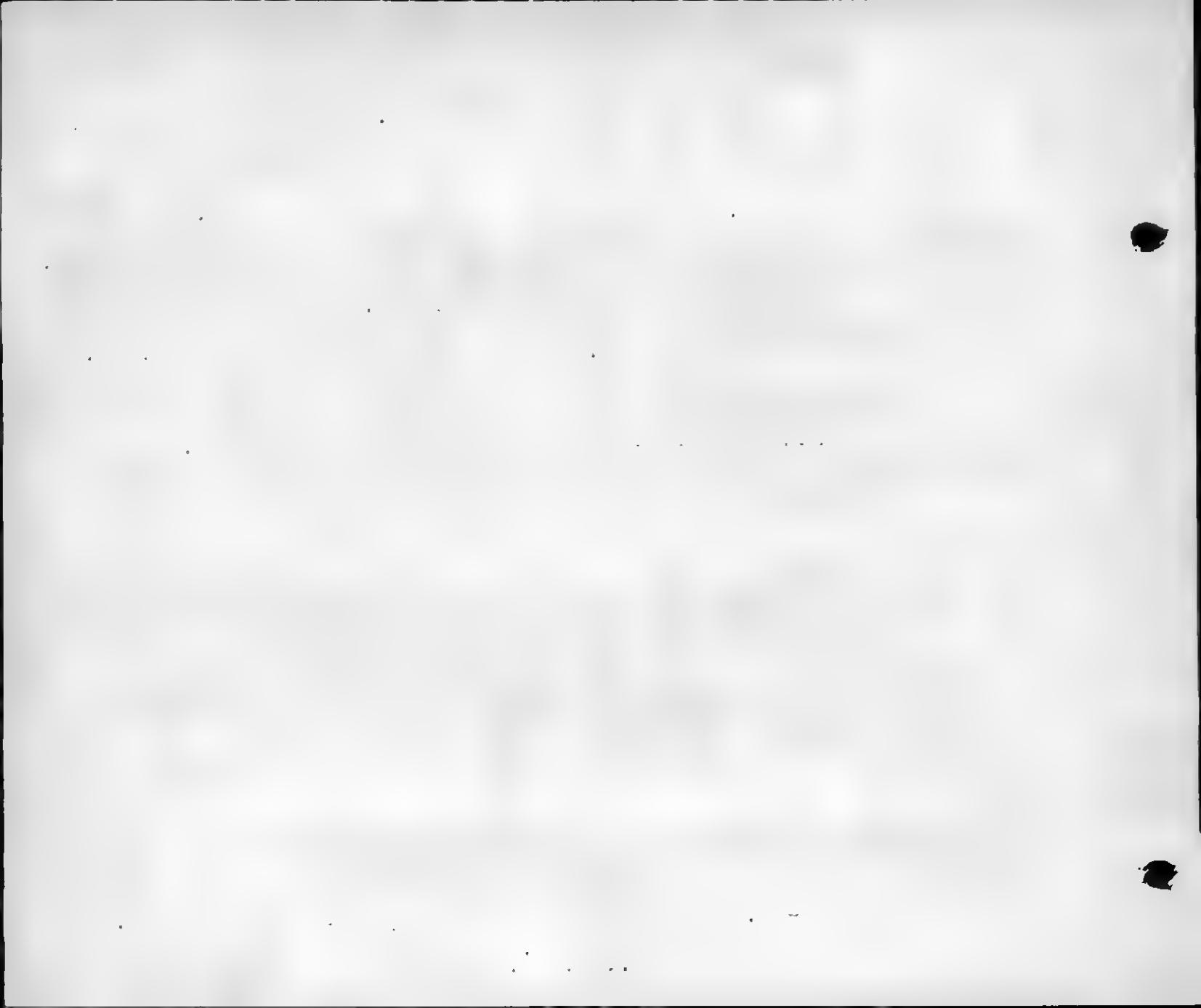
105554

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE	
Baltimore MARYLAND		Md. Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Graceland Park		c. LENGTH OF STAY IN 1b X	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6910 Norman Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Graceland Park	
3. NAME OF DECEASED (Type or print)		d. STREET ADDRESS 6910 Norman Ave.	
First STEPHEN		Middle MIDDLE	
Last WDZIECZNY		4. DATE OF DEATH Month May Day 18, Year 1960.	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH june 14, 1890.	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Grocer.	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Wdzieczny		14. MOTHER'S MAIDEN NAME Jane ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-28-6792 17. INFORMANT Mary Wdzieczny Same.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO <i>Hyper Tension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <i>(b) (c)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Jack C. Collins</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Jack C. Collins</i>		DATE SIGNED <i>5-27-60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-21-60.	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Sacred Heart of Mary Cem. 6224 Eastern Ave., Balt., Md.		22d. LOCATION (City, town, or county) (State) German Hill Rd., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles S. Geiler</i>		24a. REC'D BY REGISTRAR DATE MAY 23 '60	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO DULY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any time is necessary, please execute this certificate, writing the word "Pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.



FOR STATE
HEALTH DEPT.

539 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05555

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Dundalk

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

7307 Shipway

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Dundalk

d. STREET ADDRESS

7307 Shipway

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATHMonth
MayDay
31Year
1960

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Female

White

WIDOWED DIVORCED

Dec. 31, 1959

9. AGE (In years
last birthday) IF UNDER 1 YEAR
yrs. 5 Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

DeWitt Lee Weatherly

14. MOTHER'S MAIDEN NAME

Mary B. Moon

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) If yes give rank or date of service

16. SOCIAL SECURITY NO.

17. INFORMANT

none

D.L. Weatherly

Address

Same as #2

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

Hemoperitoneum

DUE TO

(b)

Ruptured Liver

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

INTERVAL BETWEEN
ONSET AND DEATH20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING

CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Slipped from father's grasp

20c. TIME OF INJURY Month, Day, Year

Hour Xa6X
9:30 p.m. 5/30 1960

20d. INJURY OCCURRED

While Not While
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

factory, street, office bldg., etc.)

20f. (City or town)

Home Dundalk

(County)

Baltimore Md. (State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

DATE SIGNED

5/31/60

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or country) (State)

Burial 6/1/60

Oak Lawn Cemetery

Baltimore Co., Maryland (State)

23. FUNERAL DIRECTOR

ADDRESS

ADDRESS

ADDRESS

Walter Brooks Bradley, Inc., Dundalk 22

DATE JUN 2 '60

DATE JUN 2 '60

5M 7/59

Curtis S. Evans

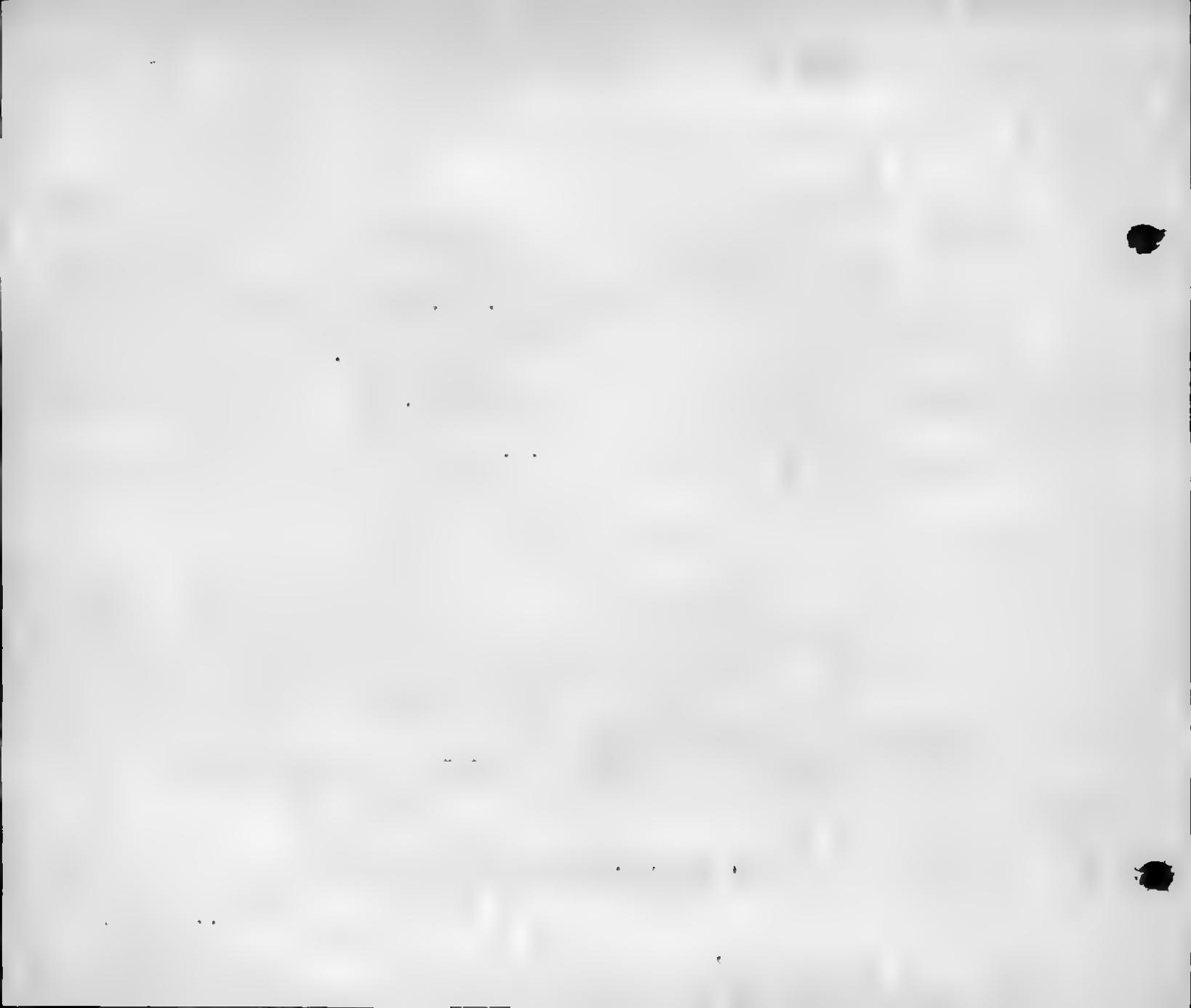
203820/XV5

203820/XV5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5581

CERTIFICATE OF DEATH

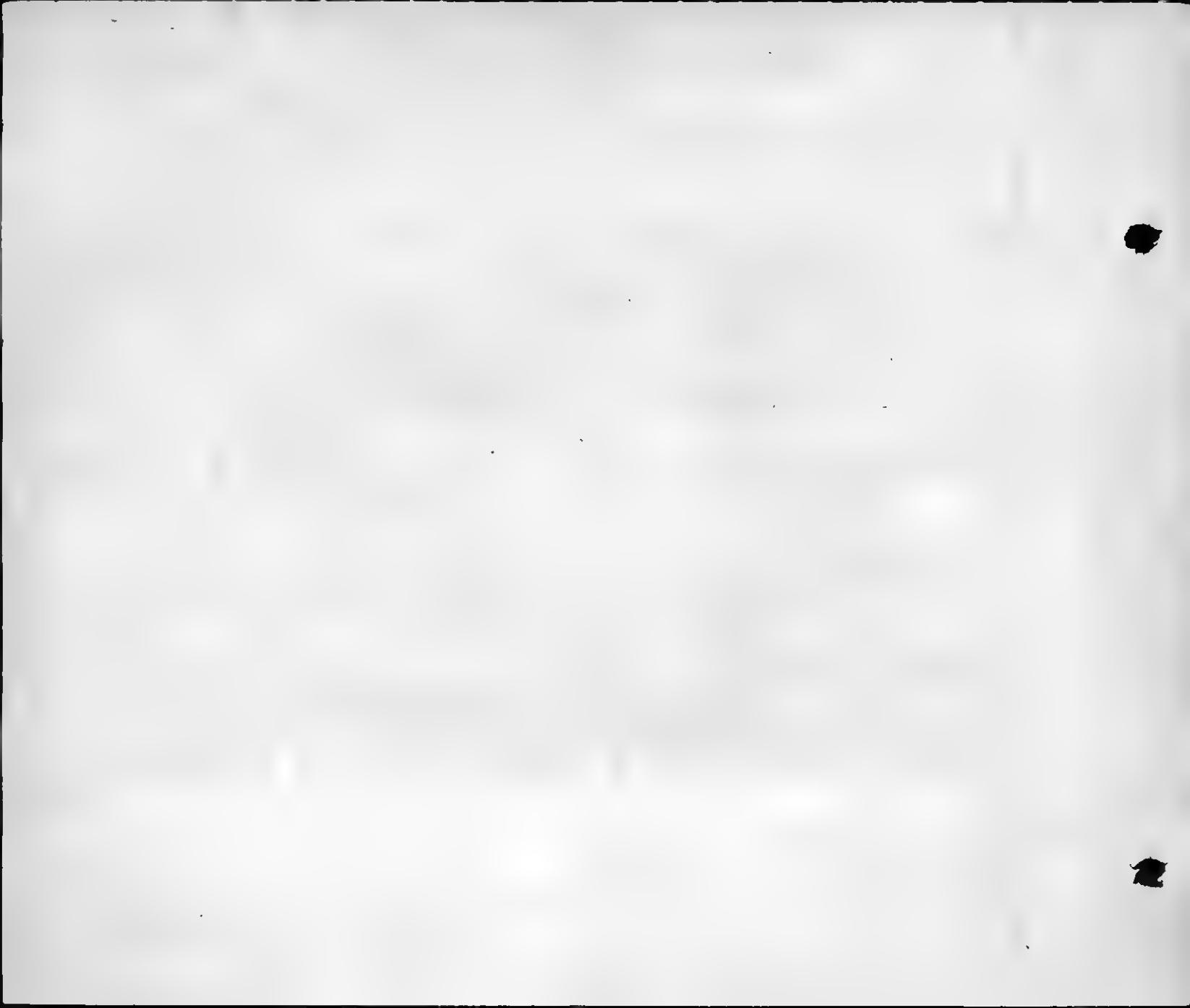
Reg. Dist. No. 45556

1. PLACE OF DEATH a. COUNTY <i>Balto.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodlawn 7</i>		c. LENGTH OF STAY IN 1b <i>5</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4105 Essex Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Irene L. Weber</i>		First <i>Irene</i>	Middle <i>L.</i>
4. DATE OF DEATH <i>May 8</i>		Month <i>May</i>	Day <i>8</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>4/22/88</i>		9. AGE (In years last birthday) <i>72 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Charles Neumann</i>	
14. MOTHER'S MAIDEN NAME <i>Mary Henner</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>1702</i>	
16. SOCIAL SECURITY NO. <i>000-00-0000</i>		17. INFORMANT <i>Dr. Burnett Ziegler</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the breast - metastatic</i>		19. INTERVAL BETWEEN ONSET AND DEATH <i>4 years</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertensive Cardiovascular disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>19</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>May 5 1960</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>Baltimore</i>	
21. I certify that I attended the deceased from <i>May 5</i> , 1960, to <i>May 8</i> , 1960, that I last saw the deceased alive on <i>May 7</i> , 1960, and that death occurred at <i>2</i> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Baltimore City, State of Maryland</i>			
ACTUAL SIGNATURE <i>Herb W. Gundersheimer Jr.</i>		DATE SIGNED <i>5/8/60</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/11/60</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. MacNabb & Son</i>		24a. REC'D. BY REGISTRAR DATE <i>MAY 11 1960</i>	
ADDRESS <i>28</i>		24b. REGISTRAR'S SIGNATURE <i>Ernest S. Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5582

CERTIFICATE OF DEATH

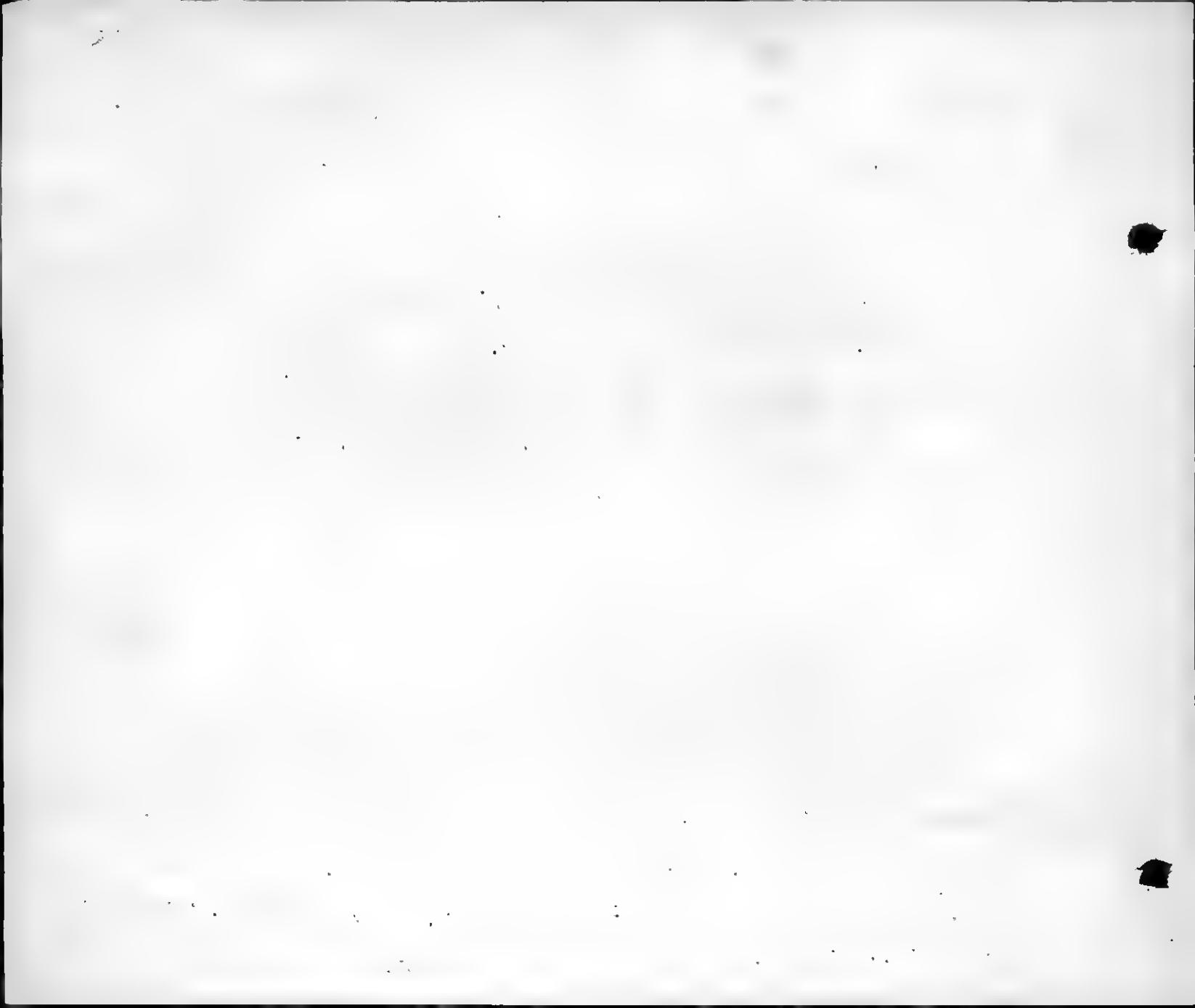
115557

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland b. COUNTY		Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall		d. STREET ADDRESS 9221 Carlisle Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9221 Carlisle Avenue									
3. NAME OF DECEASED (Type or print)		First Emma	Middle 	Last Wehrle	4. DATE OF DEATH	Month May	Day 27th	Year 1960	
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1876	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Heinrich Leonhardt		14. MOTHER'S MAIDEN NAME Ernestina Adolph							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT Mr. Frederick A. Wehrle		Address same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerosis, generalized severe DUE TO (c) Diabetes, malaise								INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D. 9660 Belair Road	(County) Baltimore 6, Maryland	(State) Maryland	
21. I certify that I attended the deceased from March 22, 1960 , to May 27, 1960 that I last saw the deceased alive on May 21, 1960 , and that death occurred at 1:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 9660 Belair Road May 27, 1960 DATE SIGNED									
ACTUAL SIGNATURE <i>Theodore J. Evans</i>		PHYSICIAN'S NAME (Type) Theodore J. Evans							
22a. BURIAL, CREMATION, burial		22b. DATE THEREOF 5/30/60	22c. NAME OF CEMETERY OR CREMATORIUM Green Mount Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		ADDRESS 5305 Harford Road #14	24a. REC'D BY REGISTRAR DATE MAY 31 '60		24b. REGISTRAR'S SIGNATURE <i>Charles J. Evans</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05558

5583

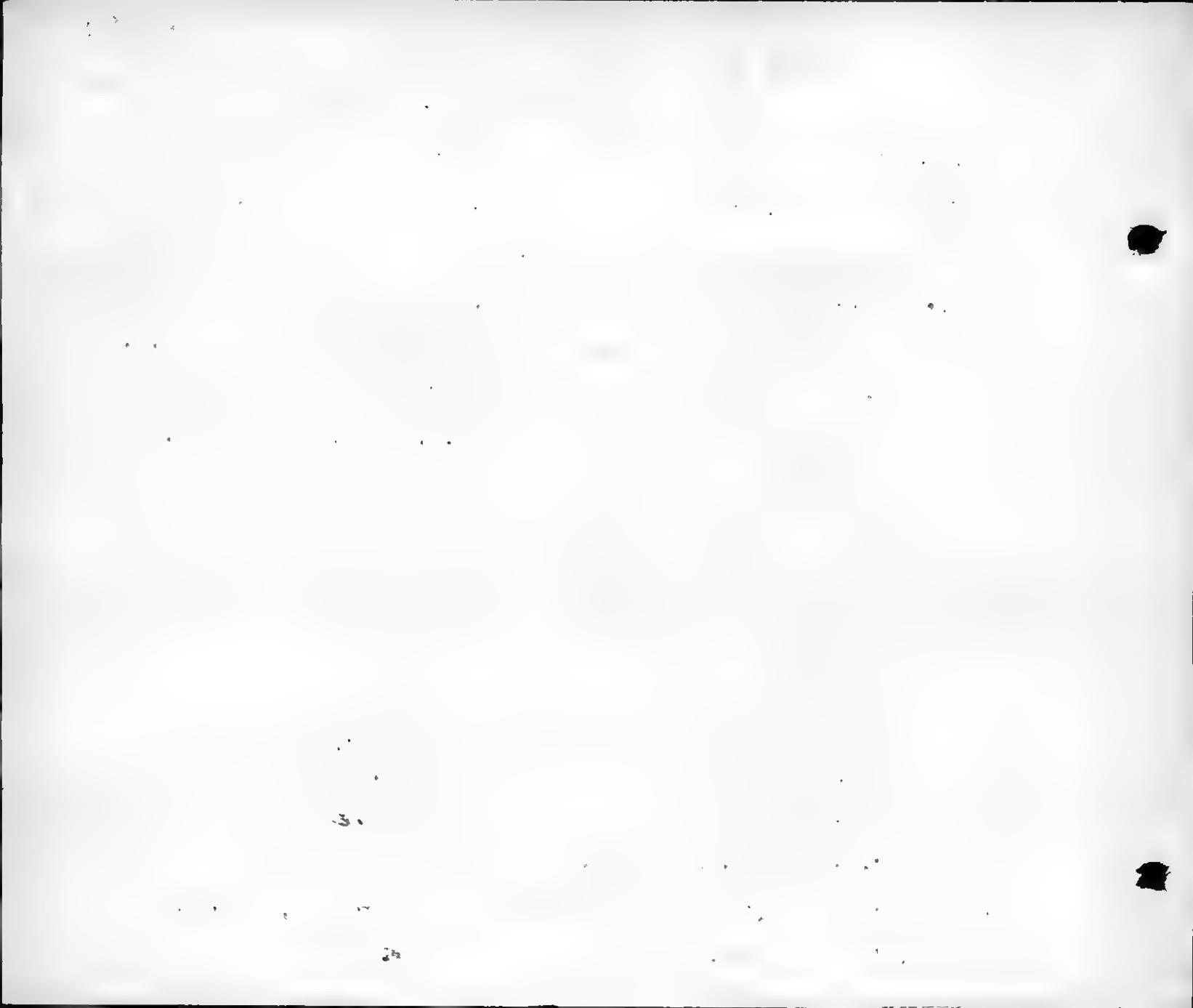
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 8201 Loch Raven Blvd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Dorothy	Middle Weidig	4. DATE OF DEATH 5 12 19 60	Month 5	Day 12	Year 19 60	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 20, 1880	9. AGE (In years last birthday) 79 yrs	IF UNDER 1 YEAR Months Days 22	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) New York City		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William H. Hevert		14. MOTHER'S MAIDEN NAME Wilhemina Krebs					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 082-01-6628D		INFORMANT Mrs. E. Grady, 2 Park Circ. Towson 4 Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Central thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Central arteriosclerosis (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day 19	Year 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 3, 1958 to May 12, 1960, that I last saw the deceased alive on May 11, 1960, and that death occurred at 1:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Ernest C. Brown, Jr. M.D. 1101 N. Calvert St. 5/12/60							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal/Burial May 14, 1960		22b. DATE THEREOF May 14, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Evergreen Cemetery		22d. LOCATION (City, town, or county) Brooklyn, New York (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		ADDRESS		24a. REC'D BY REGISTRAR MAY 16 '60		24b. REGISTRAR'S SIGNATURE Arthur E. Burns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05559

Reg. Dist. No.

5584

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millers		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		d. STREET ADDRESS 1105 Weldon Ave.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
4. SEX male		5. COLOR OR RACE white	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	7. B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. B. DATE OF BIRTH Aug. 2, 1923	9. AGE (In years last birthday) 36 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer				10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.		11. BIRTHPLACE (State or foreign country) Md.		
13. FATHER'S NAME Elmer Wells				14. MOTHER'S MAIDEN NAME Edith D. Wood				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT		12. CITIZEN OF WHAT COUNTRY? Address Mrs. Edith Wood - 1105 Weldon Ave.		
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning INTERVAL BETWEEN ONSET AND DEATH</p> <p>973.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)</p> <p>DUE TO</p> <p>DUE TO</p> <p>(c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>								
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>								
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.</p>								
ACTUAL SIGNATURE <i>A. M. France</i>		DATE SIGNED 5/23/60						
EXAMINER'S NAME (Type) A. M. France		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/26/60		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Druid Ridge Cem.		22d. LOCATION (City, town, or county) Pikesville, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Finken & Sons - Raft</i>				24a. REC'D BY REGISTRAR MAY 24 '60		24b. REGISTRAR'S SIGNATURE <i>Charles J. France</i>		

TO DIRECTOR: This certificate should be executed within 24 hours after death. If any day is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, exhumation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5585

CERTIFICATE OF DEATH

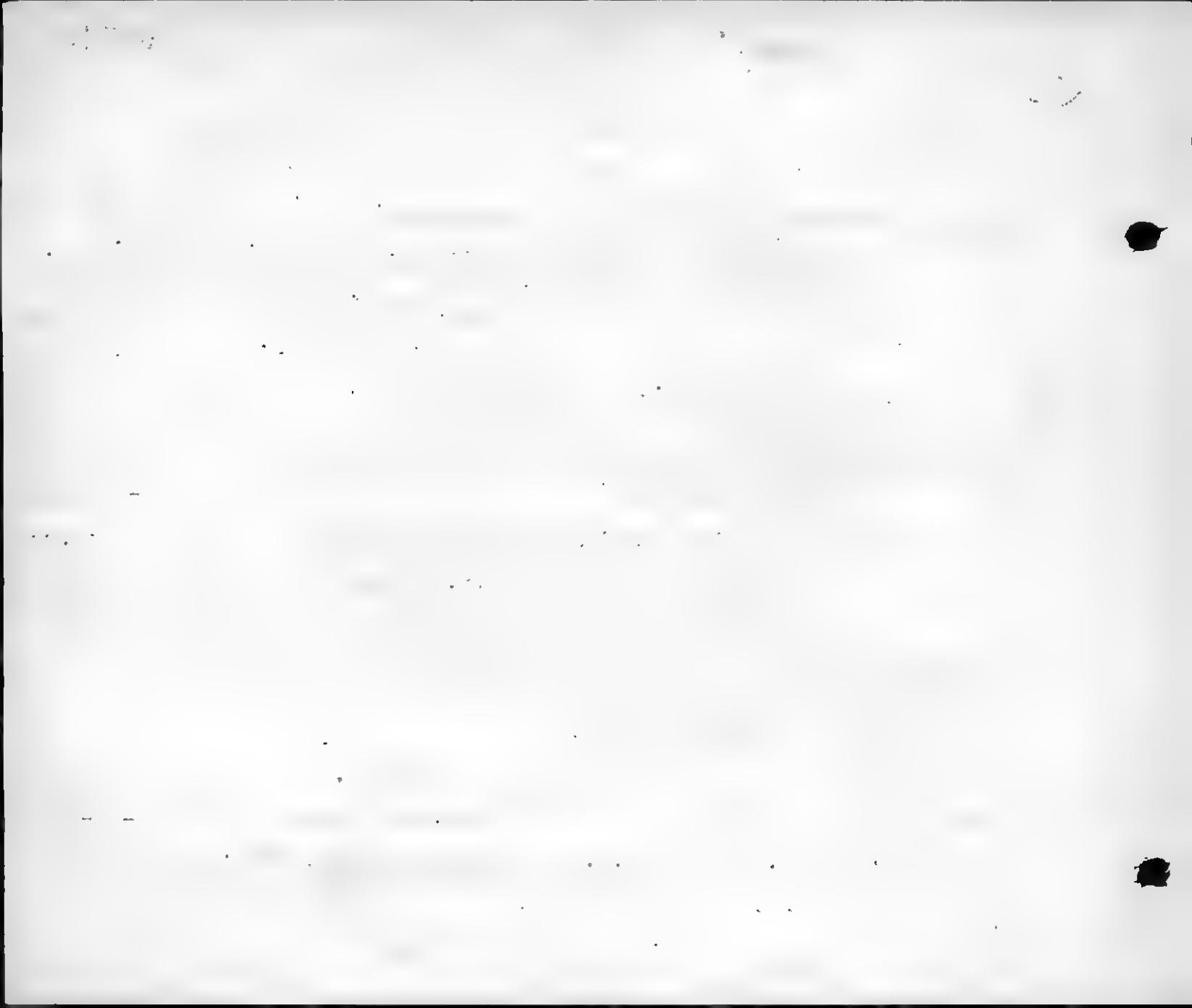
05560

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTO.		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) REISTERSTOWN		c. LENGTH OF STAY IN 1b 3 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) REISTERSTOWN	
3. NAME OF DECEASED (Type or print) AMY		First AMY	Middle CROCKETT
4. DATE OF DEATH MAY 13 1960	Month MAY	Day 13	Year 1960
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1898
9. AGE (In years last birthday) 62 yrs	10. IF UNDER 1 YEAR Months 62	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) TANGIER ISLAND, VA U.S.A.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME LOUIS CROCKETT	14. MOTHER'S MAIDEN NAME JENNY CONNOR	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia			
DUE TO 442X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Kidney and cardiac decompensation			
DUE TO (c) Arteriosclerotic C.V. Disease			
6 months			
1 year			
INTERVAL BETWEEN ONSET AND DEATH 4-5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 1959 to May 13, 1960 , that I last saw the deceased alive on May 13, 1960 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Martin E. Strobel</i>		ADDRESS (Street, city or town, state) 48 Main Street	
PHYSICIAN'S NAME (Type) Martin E. Strobel M.D.		DATE SIGNED 5-13-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-17-60	22c. NAME OF CEMETERY OR CREMATORIAL PARKWOOD
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Luck 5305 Hayfield</i>		22d. LOCATION (City, town, or county) BALTO.	(State) <i>MD</i>
ADDRESS <i>5305 Hayfield</i>		24a. REC'D BY REGISTRAR DATE MAY 18 '60	24b. REGISTRAR'S SIGNATURE <i>Charles S. Krause</i>

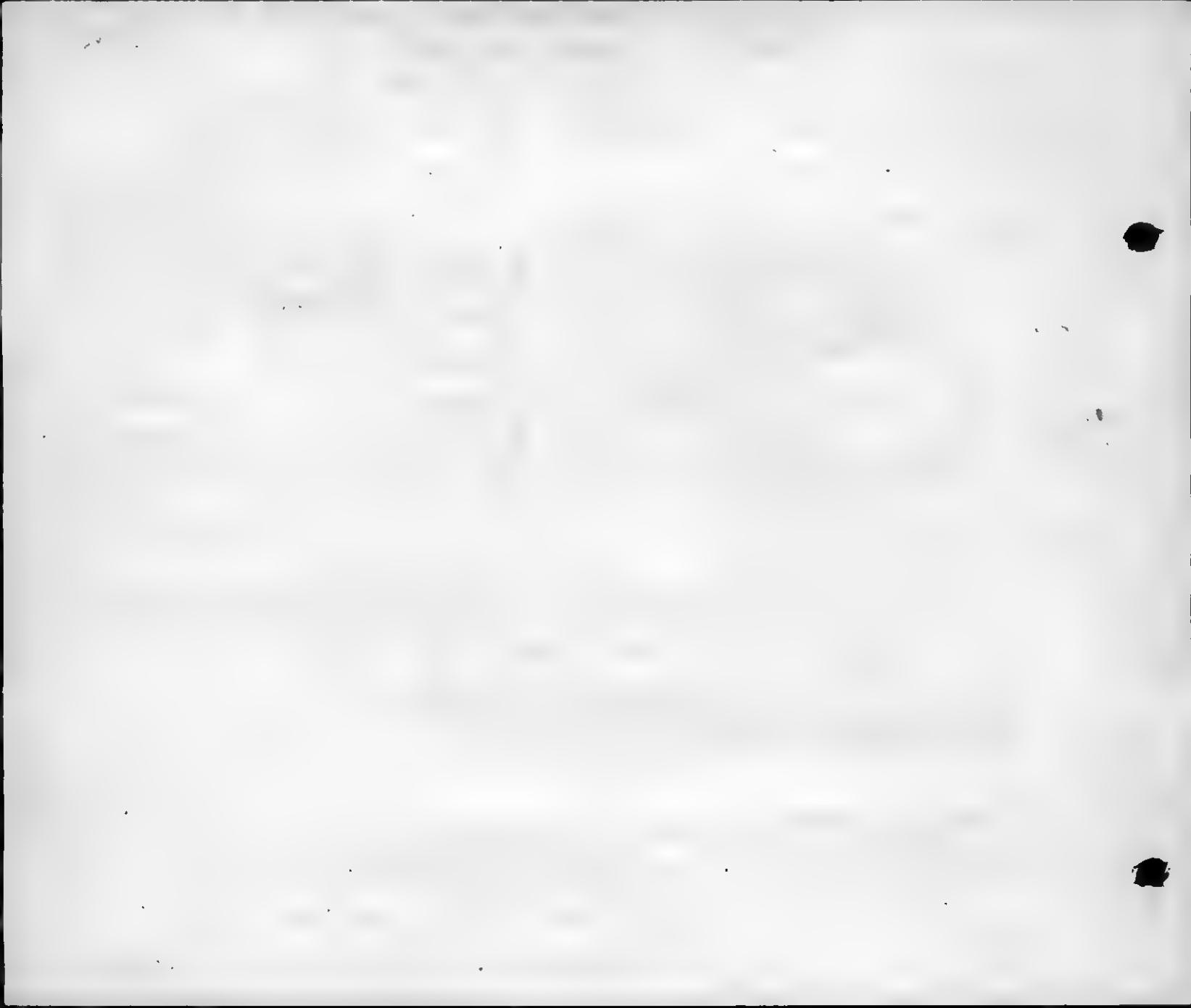


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, removal, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 5400 CERTIFICATE OF DEATH (15561)

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Baltimore</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bundalk</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arbutus 25</i>		d. STREET ADDRESS <i>1205 Fairbanks St</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>205 Fairbanks St</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Helen</i>		First	Middle	4. DATE OF DEATH <i>May 24</i>		Month	Day	Year
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 2-1906</i>		9. AGE (In years last birthday) <i>60 yrs.</i>	10. IF UNDER 1 YEAR; IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic Housewife Private Family</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>Isaac Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Mary Elizabeth Johnson</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO		17. INFORMANT <i>Nathaniel Johnson, 102 Cherry Lane</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>420</i>		DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (c)		CORONARY THROMBOSIS		INTERVAL BETWEEN ONSET AND DEATH <i>5 hours</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				HYPERTENSIVE CARDIO-VASCULAR DISEASE		8 yrs		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>Jan 1948</i> , 1948, to <i>May 24</i> , 1960, that I last saw the deceased alive on <i>May 24</i> , 1960, and that death occurred at <i>7:30 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>140 Park Ave.</i> DATE SIGNED <i>5-24-60</i>								
ACTUAL SIGNATURE <i>William C. Wade</i>		M.D.						
PHYSICIAN'S NAME (Type) <i>William C. Wade, M.D.</i>		22. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>						
22b. DATE THEREOF <i>5-27-60</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Arbutus Memorial Park</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles L. Law</i>		ADDRESS <i>802 Madison Ave.</i>		24a. REC'D BY REGISTRAR <i>DATE MAY 26 1960</i>		24b. REGISTRAR'S SIGNATURE <i>C. Law & Son</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05562

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>College Manor -</i>		d. STREET ADDRESS <i>600 Cold Spring Lane</i>	
3. NAME OF DECEASED (Type or print) <i>W. T. Vernon-Williams</i>		First <i>W.</i>	Middle <i>A.</i>
4. DATE OF DEATH <i>May 29 1960</i>		Month <i>May</i>	Day <i>29</i>
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>June 5, 1878</i>		9. AGE (In years lost birthday) <i>81 yrs</i>	10. IF UNDER 1 YEAR Months <i>8</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	10c. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>
11. CITIZEN OF WHAT COUNTRY? <i>215a</i>		12. MOTHER'S MAIDEN NAME <i>Emma V. Thomas</i>	
13. FATHER'S NAME <i>Wm. T. Miller</i>		14. MOTHER'S MAIDEN NAME <i>Emma V. Thomas</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mr. F. R. Vernon-Williams</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Metastatic Cancer of liver</i> DUE TO 156 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b). DUE TO (b) DUE TO (c)	
19. INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>—</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>May 28 1960</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	
20f. (City or town) <i>—</i>		(County) <i>—</i>	
(State) <i>—</i>			
21. I certify that (I) (this hospital) attended the deceased from <i>May 28 1960</i> to <i>May 29 1960</i> , that (I) (we) last saw the deceased alive on <i>May 28 1960</i> , and that death occurred at <i>2:30 P.M.</i> from the causes and on the date stated above		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>CRAWFORD N. KIRKPATRICK, JR.</i>		22d. ADDRESS <i>6 E. Eager St., Baltimore 2, Md.</i>	
23a. BURIAL CREMATION REMOVAL (Specify) <i>Burial June 2, 1960</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Green Mount Cemetery</i>	
23d. LOCATED ON (City, town, or county) <i>Baltimore Md</i>		(State) <i>—</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins & Sons Co.</i>		25a. REG'D BY REGISTRAR DATE <i>JUN 2 '60</i>	
ADDRESS <i>4905 York Rd.</i>		25b. REGISTRAR'S SIGNATURE <i>John W. Kline</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

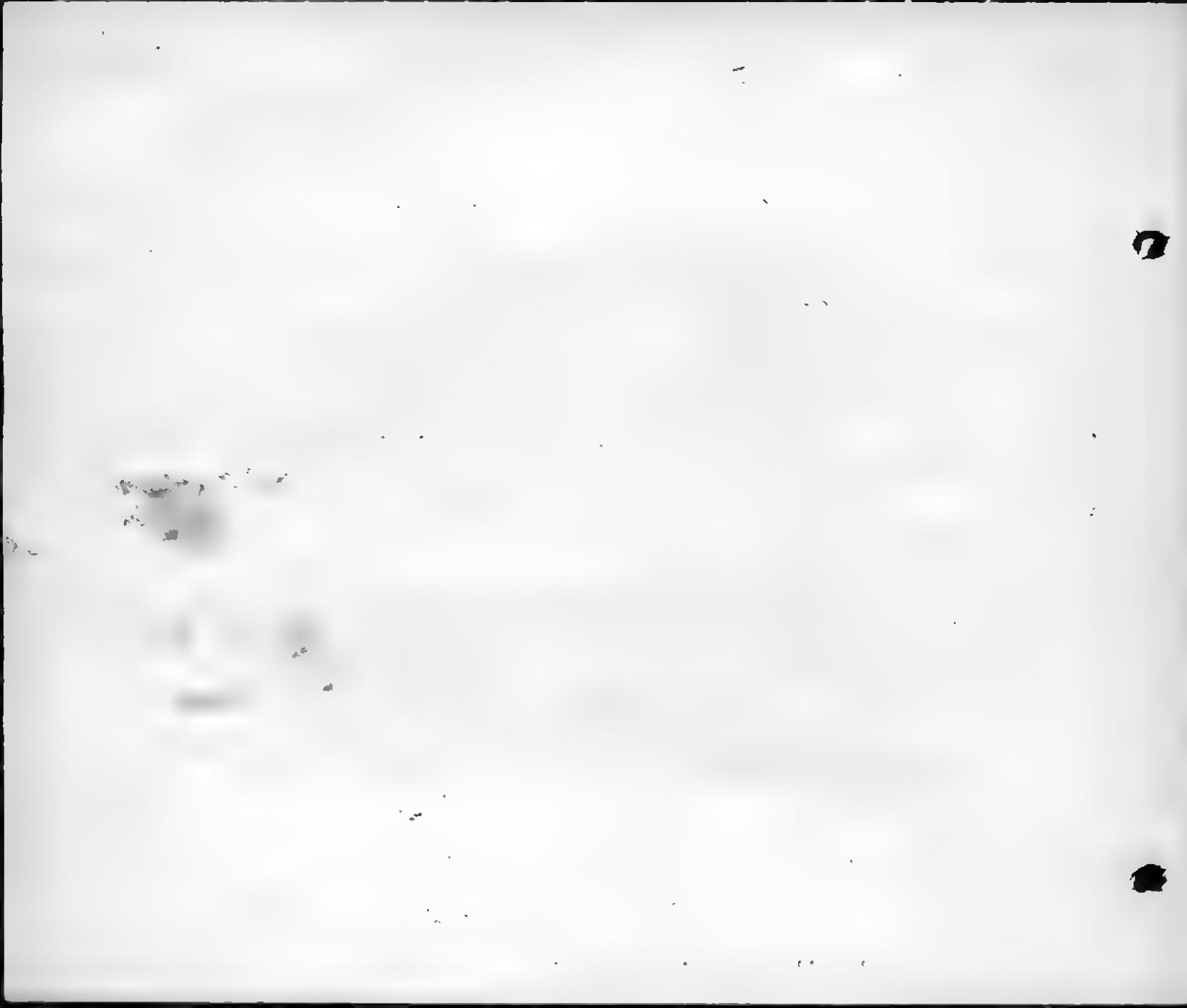
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5587

CERTIFICATE OF DEATH

05563

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 4 MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		e. STREET ADDRESS 106 WEST UNIVERSITY	
3. NAME OF DECEASED (Type or print) SAMUEL		4. DATE OF DEATH Month MAY	Day Year 8 1960
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 5-4-1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOKKEEPER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME JAMES O. WILLIAMSON		14. MOTHER'S MAIDEN NAME MARGARET	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 110-10-4482	17. INFORMANT Frank L. Smith Jr. - Cockeysville, MD
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Aclerotic Cardio		INTERVAL BETWEEN ONSET AND DEATH 22	
Conditions, if any, which give rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Vascular Disease		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-6 1960 to 5-8 1960 , that (I) (we) last saw the deceased alive on 5-6 1960 , and that death occurred at 615A , from the causes and on the date stated above.		22b. DATE SIGNED 5/8/60	
22c. SIGNATURE WALTER T. KEES		M.D.	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS COCKEYSVILLE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-11-60	23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery
24. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		ADDRESS	25a. REC'D BY REGISTRAR DATE MAY 10 1960
			25b. REGISTRAR'S SIGNATURE Office 8 hours



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detachable from the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

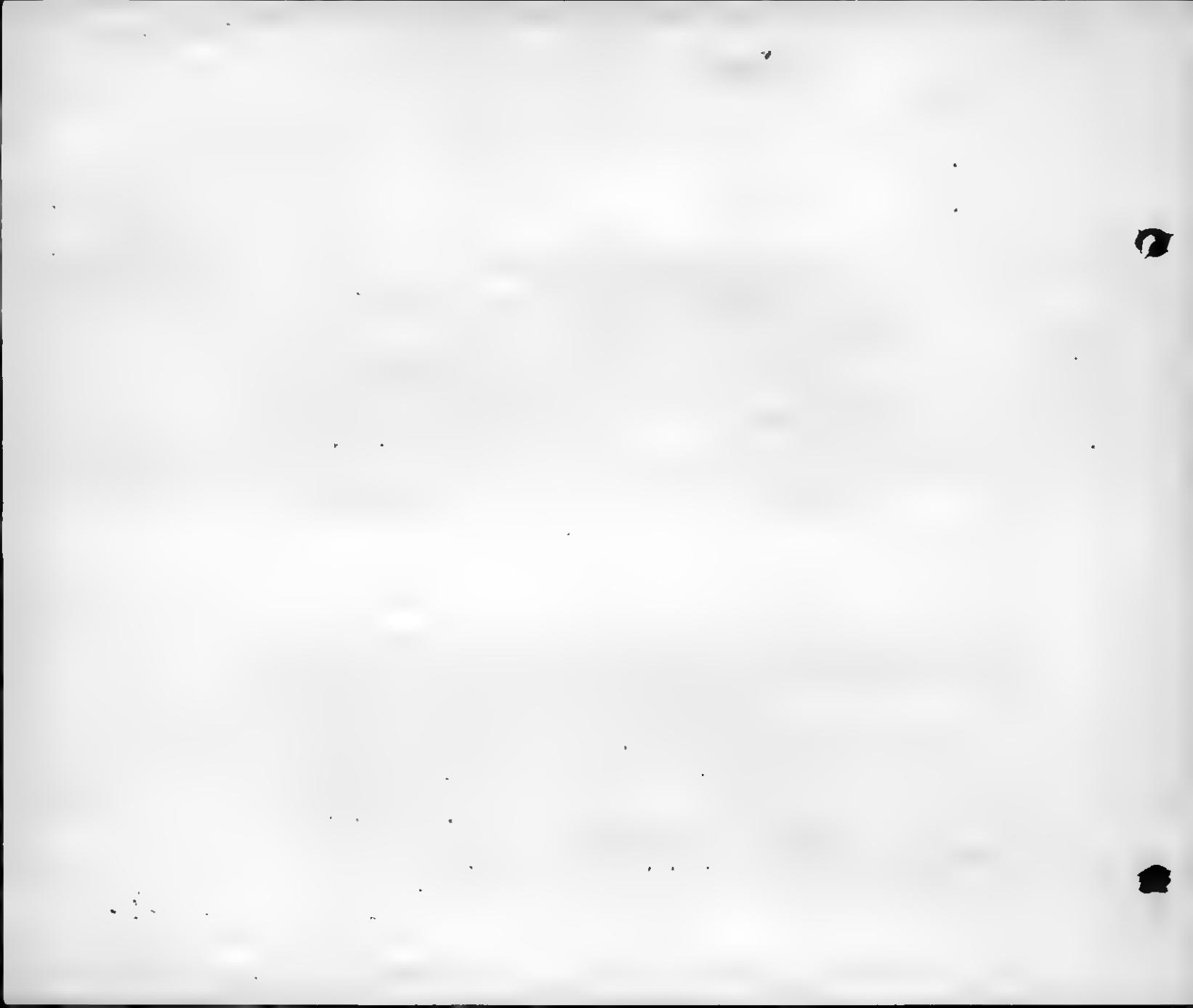
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05564

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson		c. LENGTH OF STAY IN 1b 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 23		3. STREET ADDRESS 2014 Boyd Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JAMES		First	Middle	Last	4. DATE OF DEATH May	Month	Day	Year
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1890		9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY Lumber Co.		11. BIRTHPLACE (State or foreign country) Rock Hill, S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William C. Wood		14. MOTHER'S MAIDEN NAME Minnie E. Crook						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma of stomach with widespread metastasis						INTERVAL BETWEEN ONSET AND DEATH		
15 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) _____						
		DUE TO (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Far advanced bilateral cavity pulmonary tuberculosis						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 002X						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from April 18, 1960, to May 2, 1960, that I last saw the deceased alive on May 2, 1960, and that death occurred at 10:54 AM, from the causes and on the date stated above. ACTUAL SIGNATURE Minnie						ADDRESS (Street, city or town, state) Mt. Wilson, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 5, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Edgar Hill Cem.		22d. LOCATION (City, town, or county) Balto. Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE S. Truman Schubach 3512 Frederick Ave. (29)		ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 5 '60		24b. REGISTRAR'S SIGNATURE C. S. H.		



1
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 and 2 should be filled in by the attending physician, may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

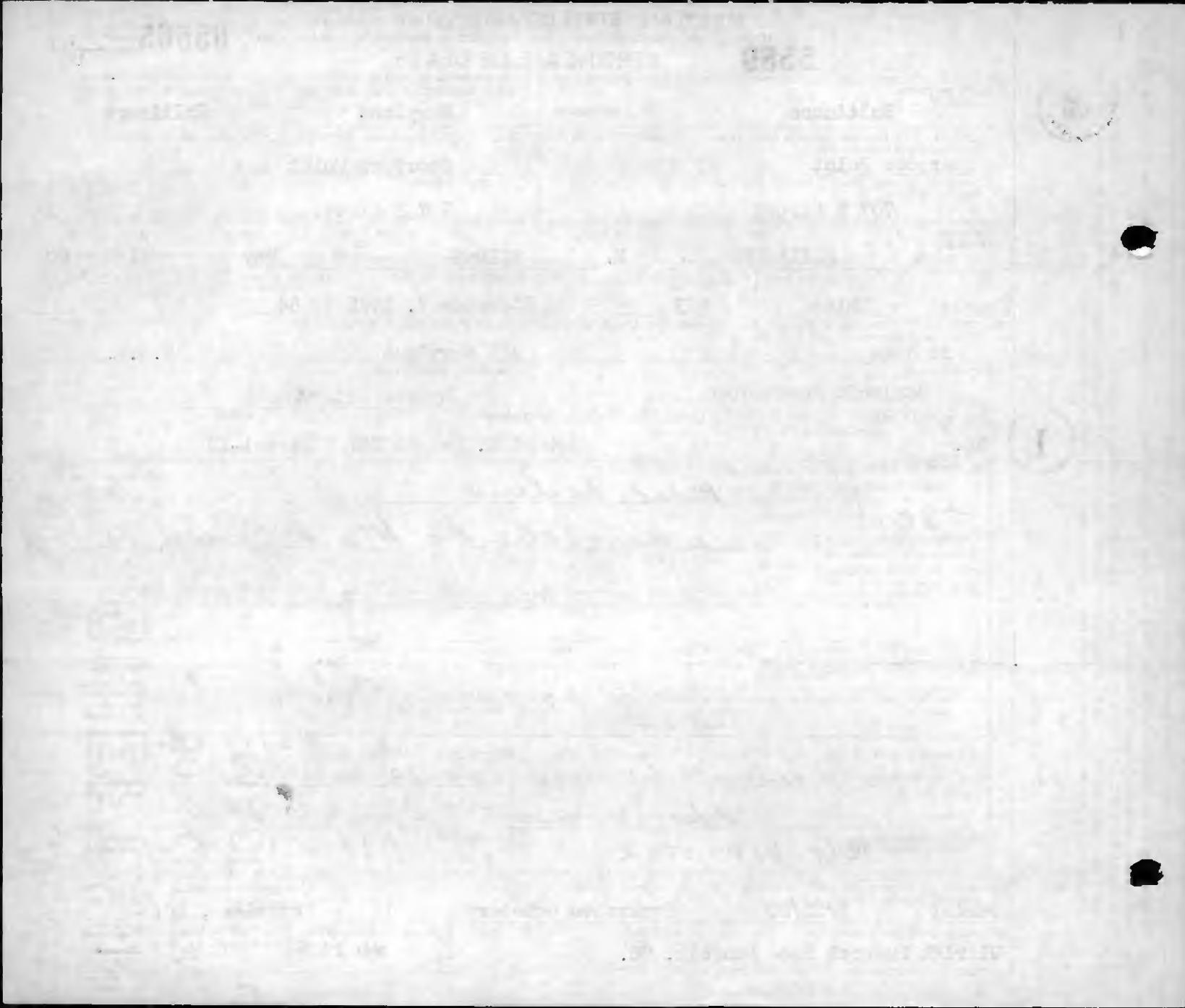
5589

CERTIFICATE OF DEATH

05565

Item 14 Film 6264 6-3-60 et

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland b. COUNTY		Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 707 E Street				707 E Street							
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
ELIZABETH		H.	WRIGHT		May	21	1960				
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.				
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		DECEMBER 7, 1875	84 yrs.	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Benjamin Buckmaster		14. MOTHER'S MAIDEN NAME Sophia Brightwell									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No.				Robert C. Wright 707 E Street-19							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Heart Failure 3 days Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Atherosclerotic Heart Disease 15 years (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)			
19											
21. I certify that (I) (this hospital) attended the deceased from Jan. 1, 1960, to May 21, 1960, that (I) (we) last saw the deceased alive on May 19, 1960, and that death occurred at 7 A.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>RG Windsor</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 25, 1960							
22c. PHYSICIAN'S NAME (Type) RG WINDSOR		22d. ADDRESS 500 1/2 St. Sp. R. 19. Ma.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/23/60		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery		23d. LOCATION (City, town, or county) Parkville, Md.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 25 '60		25b. REGISTRAR'S SIGNATURE <i>Christie L. Krause</i>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05566

Reg. Dist. No.

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If one copy is necessary, please write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 24 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10834 Reisterstown Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg	
3. NAME OF DECEASED (Type or print) Robert		First Eugene	Middle Zentz
4. DATE OF DEATH May 25, 1960		5. SEX Male	6. COLOR OR RACE White
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 19, 1917	
9. AGE (In years at birthday) 42		10. IF UNDER 1 YEAR yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofing		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Earl W. Zentz	
14. MOTHER'S MAIDEN NAME Ethel Pittinger		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. W.W. II		17. INFORMANT Mr. John Zentz	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), slotting the underlying cause last. (b) DUE TO (c)		Address Finksburg, Md.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 days	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) D. D. Caples		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 5-25-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 27, 1960	
22c. NAME OF CEMETERY OR CREMATORIUM Finksburg Cemetery		22d. LOCATION (City, town, or county) Finksburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE MAY 27 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. House	

